optional.[11] The FRBNY noted that although PTC has not changed its rules as specifically required by its commitment, it has addressed the issue that was the subject of that commitment by eliminating the pro rata charge to participants. In addition, the FRBNY stated that PTC has significantly improved its procedures for collection of principal and interest payments by encouraging issuers to use electronic means of payment and by making other operational improvements to accelerate the collection of principal and interest payments made by check.

PTC has functioned effectively as a registered clearing agency for over 8 years. Accordingly, in light of PTC's past performance and the need for continuity of the services PTC provides to its participants, the Commission believes that it is necessary and appropriate in the public interest and for the prompt and accurate clearance and settlement of securities transactions to extend PTC's temporary registration through March 31, 1999. Any comments received during PTC's temporary registration will be considered in conjunction with the Commission's review of PTC's request for permanent registration as a clearing agency under Section 17A[12] of the Act.

Intrerested persons are invited to submit written data, views, and arguments concerning the foregoing. Persons making written submissions should file six copies thereof with the Secretary, Securities and Exchange Commission, 450 Fifth Street, N.W., Washington, D.C. 20549. Copies of the submission, all subsequent amendments, all written statements with respect to the request for extension of temporary registration as a clearing agency that are filed with the Commission, and all written communications relating to the requested extension between the Commission and any person, other than those that may be withheld from the public in accordance with the provisions of 5 U.S.C. 552, will be available for inspection and copying in the Commission's Public Reference Section, 450 Fifth Street, N.W., Washington, D.C. 20549. Copes of such filing also will be available for inspection and copying at the principal office of PTC. All submissions should refer to File No. 600–25.

On the basis of the foregoing, the Commission finds that PTC's request for extension of temporary registration as a clearing agency is consistent with the Act and in particular with Section 17A of the Act.

It is Therefore Ordered, that PTC's registration as a clearing agency be and hereby is approved on a temporary basis through March 31, 1999.

For the Commission by the Division of Market Regulation, pursuant to delegated authority.[13]

Margaret H. McFarland,

Deputy Secretary.

[FR Doc. 98–8199 Filed 3–27–98; 8:45 am]

BILLING CODE 8010–01–M

[11] Letter from William Wiles, Secretary of the Board, Board of Governors of the Federal Reserve System, to John Sceppa, President and Chief Executive Officer, PTC dated (July 30, 1997).

[12] 15 U.S.C. 78q–1.

[13] 17 CFR 200.30–3(a)(50).

SMALL BUSINESS ADMINISTRATION

Data Collection Available for Public Comments and Recommendations

ACTION: Notice and request for comments.

SUMMARY: In accordance with the Paperwork Reduction Act of 1995, this notice announces the Small Business Administration's intentions to request approval on a new, and/or currently approved information collection.

DATES: Comments should be submitted on or before May 29, 1998.

FOR FURTHER INFORMATION CONTACT: Curtis B. Rich, Management Analyst, Small Business Administration, 409 3rd Street, S. W., Suite 5000, Washington, D. C. 20416. Phone Number: 202–205–6629.

SUPPLEMENTARY INFORMATION:

Title: ''Title VII Study and Report''.

Type of Request: New Request.

Form No: N/A.

Description of Respondents: Service-Disabled Veterans who own and operate Small Businesses.

Annual Responses: 1,360.

Annual Burden: 680.

Comments: Send all comments regarding this information collection to Reginald Teamer, Regional Coordination Specialist, Office of the Assistant Administrator for Veterans Affairs Small Business Administration, 409 3rd Street, S.W., Suite 6000, Washington, D.C. 20416. Phone No: 202–205–7278.

Send comments regarding whether this information collection is necessary for the proper performance of the function of the agency, accuracy of burden estimate, in addition to ways to minimize this estimate, and ways to enhance the quality.

Jacqueline White,

Chief, Administrative Information Branch.

[FR Doc. 98–8243 Filed 3–27–98; 8:45 am]

BILLING CODE 8025–01–U

SMALL BUSINESS ADMINISTRATION

Interest Rates: Quarterly Determinations

The Small Business Administration publishes an interest rate called the optional ''peg'' rate (13 CFR 120.214) on a quarterly basis. This rate is a weighted average cost of money to the government for maturities similar to the average SBA direct loan. This rate may be used as a base rate for guaranteed fluctuating interest rate SBA loans. This rate will be 5¾ percent for the April–June quarter of FY 98.

Pursuant to 13 CFR 120.921(b), the maximum legal interest rate for a commercial loan which funds any portion of the cost of a project (see 13 CFR 120.801) shall be the greater of 6% over the New York prime rate or the limitation established by the constitution or laws of a given State. The initial rate for a fixed rate loan shall be the legal rate for the term of the loan.

Jane Palsgrove Butler,

Acting Associate Administrator for Financial Assistance.

[FR Doc. 98–8244 Filed 3–27–98; 8:45 am]

BILLING CODE 8025–01–P

SOCIAL SECURITY ADMINISTRATION

Social Security Ruling, SSR 98–1p; Title XVI: Determining Medical Equivalence in Childhood Disability Claims When a Child Has Marked Limitations in Cognition and Speech

AGENCY: Social Security Administration.

ACTION: Notice of Social Security Ruling.

SUMMARY: In accordance with 20 CFR 402.35(b)(1), the Commissioner of Social Security gives notice of Social Security Ruling, SSR 98–1p. This Ruling results from the ''top-to-bottom'' review of the implementation of changes to the Supplemental Security Income childhood disability program necessitated by the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (Pub. L. 104–193). It provides a policy interpretation that children who have a ''marked'' limitation in cognitive functioning and a ''marked'' limitation in speech have an impairment or combination of impairments that medically equals Listing 2.09. It also provides guidance for determining when a child has a ''marked'' or an ''extreme'' limitation in each of these areas.

EFFECTIVE DATE: March 30, 1998.

FOR FURTHER INFORMATION CONTACT: Ken Nibali, Social Security Administration,

6401 Security Boulevard, Baltimore, MD, 21235, (410) 965–1250.

SUPPLEMENTARY INFORMATION: Although we are not required to do so pursuant to 5 U.S.C. 552(a)(1) and (a)(2), we are publishing this Social Security Ruling in accordance with 20 CFR 402.35(b)(1).

Social Security rulings make available to the public precedential decisions relating to the Federal old-age, survivors, disability, supplemental security income, and black lung benefits programs. Social Security Rulings may be based on case decisions made at all administrative levels of adjudication, Federal court decisions, Commissioner's decisions, opinions of the Office of the General counsel, and policy interpretations of the law and regulations.

Although Social Security Rulings do not have the same force and effect as the statute or regulations, they are binding on all components of the Social Security Administration, in accordance with 20 CFR 402.35(b)(1), and are to be relied upon as precedents in adjudicating cases.

If this Social Security Ruling is later superseded, modified, or rescinded, we will publish a notice in the **Federal Register** to that effect.

(Catalog of Federal Domestic Assistance, Program 96.006 Supplemental Security Income)

Dated: March 19, 1998.

Kenneth S. Apfel,

Commissioner of Social Security.

Policy Interpretation Ruling—Title XVI: Determining Medical Equivalence in Childhood Disability Claims When a Child Has Marked Limitations in Cognition and Speech

Purpose: To provide a policy interpretation that children who have a ''marked'' limitation in cognitive functioning and a ''marked'' limitation in speech have an impairment or combination of impairments that medically equals Listing 2.09. Also, to provide guidance for determining when a child has a ''marked'' or an ''extreme'' limitation in each of these areas.

Citations (Authority): Section 1614(a) of the Social Security Act, as amended; Regulations No. 16, subpart I, sections 416.902, 416.923, 416.924, 416.925, 416.926; Regulations No. 4, subpart P, appendix 1—Listing of Impairments.

Background: On December 17, 1997, the Commissioner of Social Security issued the Review of SSA's Implementation of New SSI Childhood Disability Legislation (Pub. No. 64–070), a report of a ''top-to-bottom'' review of the implementation of changes to the Supplemental Security Income (SSI) childhood disability program necessitated by the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 (Pub. L. 104–193).

As a result of the review, the Commissioner directed additional instruction on the evaluation of a combination of cognitive and speech disorders that separates speech disorders from cognitive disorders. Among other things, the Commissioner directed the issuance of a Ruling on the evaluation of speech disorders in combination with cognitive limitations. [1]

Introduction: The regulations at 20 CFR 416.906 explain that, for children claiming SSI benefits under the Social Security Act (the Act), an impairment or combination of impairments must cause ''marked and severe functional limitations'' in order to be found disabling. The regulations at 20 CFR 416.902 provide that ''marked and severe functional limitations,'' when used as a phrase, is a level of severity that meets, medically equals, or functionally equals the severity of a listing in the Listing of Impairments, appendix 1 of subpart P of 20 CFR part 404 (the listings).

The regulations at 20 CFR 416.925(b)(2) explain that, in general, a child's impairment or combination of impairments is ''of listing-level severity'' if it causes marked limitation in two broad areas of functioning or extreme limitation in one such area.

The regulations at 20 CFR 416.926 explain that we will decide that a child's impairment or combination of impairments is medically equivalent to a listed impairment if the medical findings are at least equal in severity and duration to the listed findings. We will compare the signs, symptoms, and laboratory findings concerning the child's impairment or combination of impairments, as shown in the medical evidence we have about the claim, with the corresponding medical criteria shown for any listed impairment.

In particular, the regulations at 20 CFR 416.926(a)(2) provide that, if a child has an impairment that is not described in the listings, or a combination of impairments, no one of which meets or is medically equivalent to a listing, we will compare the child's medical findings with those for closely analogous listed impairments. If the medical findings related to the child's impairment or combination of impairments are at least of equal medical significance to those of a listed impairment, we will find that the child's combination of impairments is medically equivalent to the analogous listing.

[1] This Ruling addresses evaluation of speech disorders in combination with cognitive limitations. It does not address evaluation of receptive or expressive language disorders, which can also result in disability. In addition, this Ruling does not address evaluation of the area of Cognition/Communication under the broad areas of functioning of the functional equivalence provision, as discussed in 20 CFR 416.926a(c)(4).

Policy Interpretation

I. Need To Establish a Medically Determinable Impairment

Section 1614(a)(3)(C)(i) of the Act and 20 CFR 416.906 provide that a child's disability must result from a medically determinable physical or mental impairment. Section 1614(a)(3)(D) of the Act and 20 CFR 416.908 further provide that the physical or mental impairment must result from anatomical, physiological, or psychological abnormalities which can be shown by medically acceptable clinical and laboratory diagnostic techniques. A physical or mental impairment must be established by medical evidence consisting of signs, symptoms, and laboratory findings.

The discussions in this Ruling address the evaluation of the severity of impairments affecting speech and cognition. They presume that the existence of such medically determinable impairments has already been established.

II. Terms and Definitions

A. *Cognition* involves the ability to learn, understand, and solve problems through intuition, perception, auditory and visual sequencing, verbal and nonverbal reasoning, and the application of acquired knowledge. It also involves the ability to retain and recall information, images, events, and procedures during the process of thinking. There are many impairments that can cause limitations in cognition, such as genetic disorders or brain injury.

B. *Speech* is the production of sounds (phonemes) in a smooth and rhythmic fashion for the purposes of oral communication. It includes articulation, voice (pitch, volume, quality), and fluency (the flow, or rate and rhythm, of speech). Understandable speech results from precise neuromuscular functioning of the speech mechanism (e.g., lips, tongue, hard palate, vocal folds, respiratory mechanism), and intact structure and functioning of the speech centers in the brain.

There are many impairments that can cause limitations in speech, such as brain lesions or cortical injury resulting

in apraxia; other neurological abnormalities, such as cerebral palsy producing dysarthria; or structural abnormalities, such as cleft palate producing hypernasality. Speech differs from language (receptive and expressive). Speech is the production of sounds for purposes of oral communication; language provides the message of the communication, and involves the use of semantics (e.g., vocabulary), syntax (e.g., grammar), and pragmatics (i.e., use of language in its social context) in the understanding and expression of messages.

III. Limitations in Cognition and Speech

A. *Mental Retardation and Speech Impairment.* In the childhood disability program, children who have a valid diagnosis of mental retardation (''significantly subaverage general intellectual functioning with deficits in adaptive functioning'') have, by definition, at least a ''marked'' cognitive limitation. However, a child may have a marked limitation in cognitive functioning without being diagnosed with mental retardation. (See B.)

Listing 112.05 is used to evaluate mental retardation, which is demonstrated by significantly subaverage general intellectual functioning with deficits in adaptive functioning. A child's impairment meets Listing 112.05D or 112.05F when the child has a diagnosis of mild mental retardation and a physical or other mental impairment imposing ''additional and significant limitation of function'' [i.e., more than minimal limitation of function]. In these listings, the significantly subaverage general intellectual functioning needed to establish that component of the diagnosis of mild mental retardation is shown by a valid verbal, performance, or full scale IQ of 60 through 70 (under Listing 112.05D) or ''marked'' limitation in the area of cognition/communication (under Listing 112.05F, by reference to Listing 112.02B1b or 112.02B2a). Of course, mild mental retardation may be sufficiently severe in itself to meet the criteria of Listing 112.05 A or E. More impairing cases of mental retardation (i.e., moderate, severe, or profound) will meet the criteria of Listing 112.05 B or C.

A speech impairment may satisfy the criterion for a physical or other mental impairment imposing ''additional and significant limitation of function'' under Listings 112.05D and 112.05F when it causes more than minimal limitation of function. To satisfy this criterion, a child's problems in speech must be separate from his/her mild mental retardation.

- A child with mild mental retardation may have speech problems resulting from an impairment of known etiology that is clearly separate from the mental retardation; e.g., a congenital disorder (as with a congenital brain injury, or a cleft palate resulting in hypernasality) or an acquired disorder (as in a child who already has mental retardation and who suffers a traumatic head injury resulting in a neurological or physical problem affecting the ability to produce speech sounds).
- A child with mental retardation may also have speech problems resulting from an impairment of unknown etiology that nevertheless is clearly separate from the mental retardation; e.g., poorly intelligible speech of unknown etiology.

It is possible for a child with mental retardation to have limitations in speech that do not constitute an impairment separate from the mental retardation. In a child with mental retardation, speech development is often commensurate with the level of cognitive functioning. Therefore, in the absence of an impairment of speech that is separate from the child's mental retardation, a speech pattern that has been and continues to be consistent with the child's general intellectual functioning is not regarded as separate from the mental retardation and will not be found to satisfy the criterion in Listings 112.05D and 112.05F for a physical or other mental impairment imposing additional and significant limitation of function.

On the other hand, if a child's speech development is not even commensurate with his/her general intellectual functioning (i.e., is significantly below that which would be expected given the level of cognitive functioning), then the limitations in speech would be regarded as an impairment separate from the mental retardation that would satisfy the criterion in Listings 112.05D and 112.05F for a physical or other mental impairment imposing additional and significant limitation of function.

B. *''Marked'' Limitations in Cognition and Speech.* A child whose impairment does not meet the capsule definition of mental retardation in Listing 112.05 may nevertheless have a marked limitation in cognitive functioning. When such a child also has an impairment that causes a ''marked'' limitation in speech (see Table 1 and Section VI), the combination of limitations in cognition and speech will be found medically equivalent to Listing 2.09 in part A of the listings.[2]

This policy interpretation regarding the evaluation of a combination of cognition and speech impairments is an exception to the guidance in listings section 2.00B3. That section explains that impairments of speech due to neurologic disorders should be evaluated under 11.00–11.19, the neurological listings generally used to evaluate impairments in individuals age 18 or older. For the purposes of this Ruling only, however, neither the neurological listings in 11.00–11.19, nor those in 111.00 for individuals who have not attained age 18 will be used; only Listing 2.09 will be employed.

C. *''Extreme'' Limitations in Cognition and Speech.* An impairment(s) that causes an ''extreme'' limitation in cognition or in speech is always of listing-level severity and, thus, will always meet or equal the severity of a listing.

1. Cognition. The vast majority of children with ''extreme'' limitations in cognition will have mental retardation and will have an impairment that meets one of the listings in 112.05. Very infrequently, however, a child with an IQ in the ''extreme'' range will not have the deficits in adaptive functioning needed to establish the diagnosis of mental retardation. In these rare instances, the validity of the IQ and the assessment of adaptive functioning should be verified. If both appear accurate and a diagnosis of mental retardation is not supportable, the child's impairment will nevertheless medically equal the criteria of a childhood mental disorders listing; e.g., Listing 112.02.

2. Speech. Listing 2.09 recognizes disability on the basis of an ''[o]rganic loss of speech due to any cause with inability to produce by any means speech which can be heard, understood, and sustained.'' This listing applies to children as well as adults, and describes the most extreme limitation of speech. However, children with less serious limitations of speech than are described in Listing 2.09 may still have an ''extreme'' limitation, as noted in Table 1, and, therefore, may also have impairments that meet or equal the requirements of a listing.

IV. Documenting Limitations in Cognition and Speech

A. *Documentation of Severity.* 1. Evidence of the severity of cognitive

[2] In general, part A of the listings contains medical criteria that apply to persons age 18 and over; part B contains medical criteria that apply to persons under age 18. However, the medical criteria in part A may also be applied in evaluating impairments in persons under age 18 if the disease processes have a similar effect on adults and younger persons, as in Listing 2.09. See 20 CFR 416.925(b).

limitation should generally include the results of psychological testing, with subtest scores, and the psychologist's interpretation of the results, including his/her conclusion regarding the validity of the testing. The psychological test scores must also be sufficiently current for accurate assessment.[3]

Evidence of the severity of cognitive limitation should also include information about learning achievement (e.g., test scores, school performance records) and descriptions (from medical and lay sources) of the child's ability to do age-appropriate, cognitively related tasks and activities at home and school.

2. Evidence of the severity of speech limitation should generally include the results of a comprehensive examination of the child's speech (articulation, voice, fluency), and descriptions of the child's speech in daily circumstances (e.g., the sounds a child produces, the percentage of intelligibility of the child's speech). These descriptions come from persons who have opportunities to listen to the child; i.e., both lay and professional sources (see Section VI.C.). The evidence must be sufficient and recent enough to permit a judgment about the child's current level of functioning. In some instances, it may be necessary to obtain a consultative examination in order to assure recency of the evidence.[4]

B. *Sources of Evidence.* Evidence of a child's cognitive functioning and speech may be available from various sources. For example, if a child is receiving special education services, the school should be able to provide records of testing, clinical observations, and classroom performance. Examples of some sources include the following.

1. Multidisciplinary teams. Children being assessed for possible developmental problems are evaluated by a multidisciplinary team that may include a psychologist, physician, speech-language pathologist, audiologist, special educator, teacher, and other related specialists as needed; information concerning the child's cognitive abilities and speech should be available from the team's comprehensive report(s). The remediation plans for infants and toddlers (birth to age 3) are reviewed every 6 months. School-aged children in the public school system should be reassessed at least every 3 years.

2. Comprehensive evaluations. A child with documented problems in cognition and speech who is already receiving special education services must have had a comprehensive evaluation prior to receiving such services. That evaluation should include results of formal testing and clinical observations.

3. Individualized plans. Children who are cognitively limited, speech-impaired, or limited in both areas, may receive special education services in Early Intervention Programs (infants and toddlers, from birth to age 3 years), or in school-based educational programs in preschool, kindergarten, elementary, and secondary school. Annual goals and objectives for such programs, as well as test results, are documented yearly in individualized plans of intervention: for infants and toddlers, in the Individualized Family Service Plan (IFSP); for children age 3 and older, in the Individualized Education Program (IEP).

4. Speech-language progress notes. For any child receiving speech-language special education services, the speech-language pathologist should have prepared periodic progress notes that document the child's current strengths and weaknesses.

5. Other sources. Other potential sources of evidence of severity include reports from parents, daycare providers, social workers, case managers, teachers, treatment sources, or consultative examinations.

V. Rating Limitations in Cognition and Speech

When the outcome of a disability determination depends on conclusions regarding a child's cognitive and speech limitations, experts in the fields of cognitive assessment and speech-language should participate in the evaluation of the claim whenever possible.

A. *Cognition.* Marked cognitive limitation is usually identified under any of the following circumstances:[5]

1. When standardized intelligence tests provide a valid score that is 2 Standard Deviations (SDs) or more below the norm for the test (but less than 3 SDs), with appropriate consideration of the Standard Error of Measurement.

2. In the absence of valid standardized scores, when a child from birth to attainment of age 3 has an impairment or combination of impairments that results in cognitive functioning at a level that is more than one-half but not more than two-thirds of the child's chronological age.

3. When a child from age 3 to attainment of age 18 has an impairment or combination of impairments that causes ''more than moderate'' but ''less than extreme'' limitation in cognitive functioning; i.e., when the limitation interferes seriously with the child's cognitive functioning.

A finding that a limitation in a child's cognitive abilities is ''marked'' or ''extreme,'' or that it is less than ''marked,'' must be based on all of the relevant evidence in the case record.

B. *Speech.* Marked limitation in speech will be evaluated under the guidelines in Table 1. Section VI explains how to use the table.

VI. Table 1: Guidelines for Evaluating the Severity of Speech Impairments

A. *General.* 1. The guidelines for evaluating severity in Table 1 use age groupings that do not correspond to the age ranges in 20 CFR 416.926a and the childhood mental disorders listings but, rather, are related to the developmental progression of speech; e.g., the aspects of speech development that tend to occur between birth and age 2. The guidelines refer to errors that are not typical or expected for the particular age grouping; e.g., 2 to 3½ years. This principle of evaluation is based on the fact that speech development, like fine and gross motor development, is incremental and follows milestones as predictable as rolling over, crawling, and standing. The upper age category in Table 1 is age 5 and older because, by age 5, almost all sounds are mastered; however, the few age-appropriate sound errors still occurring after age 5 involve sounds (e.g., ''r,'' ''th'') that may not be completely refined until age 8. Thus, by age 8, a child should have a repertoire of sounds that is complete and accurate; by definition, any misarticulations beginning at age 8 are inappropriate.

A child's speech patterns and misarticulations, and when these occur, can be indicative of whether a child's speech is developing, or has developed, appropriately.

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[3] The interpretation of the psychological testing is primarily the responsibility of the psychologist or other professional who administered the test. When an appropriate medical professional has provided test results that meet the standards in SSA regulations (e.g., that are consistent with the other evidence in the case record, or that note and resolve discrepancies between the test results and the child's customary behavior and daily activities), the adjudicator will ordinarily accept the results, unless contradictory evidence in the case record establishes that the results are incorrect.

[4] The same principles apply here as for psychological testing. When an appropriate medical professional has provided test results that would meet SSA standards (e.g., that are consistent with the other evidence in the case record, or that note and resolve discrepancies between the test results and the child's customary behavior and daily activities), the adjudicator will ordinarily accept the results, unless contradictory evidence in the case record establishes that the results are incorrect.

[5] The basic definitions of ''marked'' and ''extreme'' limitation are provided in 20 CFR 416.926a(c)(3). This Ruling provides further interpretation of the definitions of ''marked.''

2. Table 1 is divided into three columns: Chronological Age or Cognitive Level, Marked Limitation, and Extreme Limitation. Once the appropriate category for chronological age or cognitive level is identified (see Section B), use the second and third columns to determine whether a child with a speech impairment has a ''marked'' or an ''extreme'' limitation in speech. The evaluation of the severity of the speech impairment should be based on evidence concerning:

- The sound production and intelligibility of the child's speech in relation to the listener and the topic of conversation (see Section C); and
- The child's speech patterns (see Section D).

A finding that a limitation in speech is ''marked'' or ''extreme,'' or that it is less than ''marked,'' must be based on all of the relevant evidence in the case record.

3. If the limitation in speech is ''marked'' and the child also has a ''marked'' limitation in cognition, or if the limitation is ''extreme,'' consider the duration of the impairment (see Section E).

4. Note on use of terms.

a. The terms used in the Table 1 are typically found in reports of comprehensive speech-language evaluations. However, some reports may not use these terms or may use the terms differently than intended in the table. If the evidence does not use the descriptors employed in the table, or it is not clear how the terms are used, it may be necessary to contact the source to clarify the information.

b. Terms such as ''poor,'' ''severe,'' ''mild,'' or ''marked'' may be used in the evidence to describe a child's functioning. These terms have different meaning to different people. Therefore, when such terms are not illustrated or explained by the evidence, it may be necessary to contact the source for an explanation of their meaning.

B. *Chronological Age and Cognitive Level.* 1. Cognitive level is the level of a child's thinking. In many instances, cognitive and speech development are highly correlated, so that a child whose cognitive level is below chronological age will often have speech development that is appropriate to the cognitive level rather than the chronological age. Thus, although a child's speech patterns may not be appropriate from the perspective of his/her chronological age, they may be appropriate to his/her cognitive level. For example, a 4-year-old child's cognitive level may be that of a child in the age range 2 to 3½ because of an impairment affecting cognitive functioning. Speech at the 2½-to-3-year level would be considered a function of (related to) the child's cognitive level.

2. Use a child's chronological age for evaluation of severity:

a. When the child is 8 years of age or older; or

b. When the child is less than 8 years of age and the limitations in speech are the result of a congenital or acquired impairment of speech, either structural or neurological (e.g., cleft palate, dysarthria, apraxia of speech).

3. *Use a child's cognitive level for evaluation of severity* in all other cases.

4. Determining the cognitive level.

a. The cognitive level may be determined from information in the case record; e.g., score from the Bayley Scales of Infant Development, Wechsler composite scores (verbal, performance, full scale), or Stanford-Binet score. Most children with ''marked'' limitation in cognitive functioning will have evidence of testing showing the cognitive level, or from which the cognitive level can be determined. Particularly in the case of young children, the cognitive level is frequently included along with test scores in evaluation reports. See Section IV.B. for a list of examples of sources of evidence.

b. Developmental testing often addresses a child's progress in several areas, and developmental levels may be reported for cognition and at least one other area; e.g., motor or social functioning. For purposes of Table 1, use the level reported for the child's cognitive ability.

c. If the cognitive level is not clearly indicated in the case record or cannot be determined from the evidence, it may be necessary to recontact a source who has already evaluated and provided evidence about the child or to purchase a consultative examination. If a language level based on the total language score is included in the case record, it may be used as a proxy for the cognitive level for children up to age 6. Whether additional information will be needed will depend on the facts of the case.

C. *Sound Production and Intelligibility.* 1. Evidence of sound production and intelligibility.

a. Ideally, to assess a child's sound production and the intelligibility of speech, descriptions are needed from at least two listeners, one lay and one professional. If there is a conflict in the evidence concerning the child's sound production or intelligibility, it may be necessary to obtain a third descriptive statement, preferably from an additional professional source who is familiar with the child.

b. Listeners will either be familiar with the child (i.e., have listened to the child daily or frequently) or unfamiliar (i.e., have listened to the child infrequently). Familiar lay sources are people who know the child well, such as parents, relatives, and neighbors.

c. A professional source is a person who has training and experience in evaluating a child's speech. Examples of professional sources may include, but are not limited to, speech-language pathologists, special education teachers, pediatric neurologists, pediatricians, and occupational therapists. A professional source may also be a familiar listener (e.g., a source who provides regular treatment) or an unfamiliar listener (e.g., a consulting examiner).

2. Sound production refers to a young child's vocalizations (e.g., ''cooing'') that gradually become more complex and develop into recognizable speech sounds. For example, beginning around 4 to 5 months of age, an infant engages in ''babbling,'' which consists of consonant-vowel sequences (e.g., ''ba-ba''). Later, around 10 months of age, an infant begins ''jargoning,'' which is the production of strings of speech sounds having the intonational patterns of adult speech. The variety, pitch, and intensity, of a child's sounds at this stage of development are important factors in the assessment of a child's very early speech development. Eventually, the young child uses his/her repertoire of speech sounds to imitate and produce words; this repertoire should be complete by 8 years of age.

3. Intelligibility (clarity) means the degree to which the child can be understood by the listener. To rate the intelligibility of a child's speech, a listener (regardless of whether a professional or a lay source) must be asked to provide information about how well the child can be understood, preferably in terms of a percentage (e.g., 50% of the time) or fraction (e.g., half the time).

a. The expected degree of intelligibility increases with a child's age, with a typical rate of 50% intelligibility to family members at 2 years of age, and almost full intelligibility to all listeners by attainment of 4 years of age.

b. Intelligibility is also affected by the extent to which the listener is familiar with the child's speech and the topic of conversation.

- Ratings of intelligibility should be evaluated with respect to the familiarity of the listener with the child and the frequency of contact; however, see paragraph c.

• Consideration must also to be given to the familiarity of the listener with the topic (i.e., content) of the speech. When the child's speech is difficult to understand and the topic of the conversation is unknown or not familiar to the listener, the intelligibility of the message is reduced.

c. Ratings of intelligibility by unfamiliar listeners for whom the topic of conversation is unknown assume increasingly greater importance as children age. Young children typically talk about what is immediately present in their environment, and listeners may be able to use external clues to understand such children's speech. As children age, however, the topics of their conversation should become less embedded in the immediate physical context (e.g., they talk about past or future events); the unfamiliar listener, therefore, has fewer clues available for understanding the child's speech. The older a child becomes, the more intelligible he/she needs to be in school and social situations and with infrequent listeners or strangers.[6]

D. *Speech Patterns.* 1. Speech patterns refers to sounds, omissions, distortions, or phonological patterns, and the fluency, or rate and rhythm, of speech.

2. Phonological patterns refers to the selection, sequence, combination, and placement of sounds that the rules of sound production comprise. A child's ''phonological development'' (the acquisition of sounds and understanding of their use) consists of learning these rules through instinctual experimentation and practice. For example, a child may use ''yedow'' for ''yellow,'' or ''ba-oon'' for ''balloon,'' until normal phonological development makes possible his/her use of the ''l'' sound in a word. A child's phonological patterns are appropriate if they are typical for his/her cognitive level; they are inappropriate if they are not typical for his/her cognitive level. Information about phonological patterns is included in speech-language evaluations.

3. Misarticulations are incorrect productions of speech sounds, and may include various kinds of ''speech errors''; e.g., distortions (such as vowel distortions, lateralized ''s''), substitutions (such as lisping), or omissions of sounds. Such errors may occur in the beginning, middle, or end of words. As noted previously, certain misarticulations are appropriate because they are typical of various stages of phonological development. As a child grows older, certain misarticulations are not typical of his/her group and are, thus, inappropriate. The nature of the misarticulation and its placement in the word can affect the seriousness of the ''speech error'' and its effect on intelligibility. For example, the omission of consonant sounds at the beginning of many words can render much of a child's speech unintelligible.

4. Dysfluent speech is a break in the rhythm and rate of speech. Children between ages 2½ and 4 may go through a period in which they produce ''normal dysfluencies.'' The pattern of a child's dysfluencies, and whether it is typical or atypical for the child's cognitive level, can be indicative of whether a child's speech is developing appropriately.

5. Voice refers to the pitch, quality, and intensity of a child's voice. Aberrations in voice are not a function of the child's cognitive level and are usually atypical at any age.

6. Sources of information. Information concerning a child's speech in relationship to his/her cognitive level must be provided by persons who are knowledgeable about the specific milestones of development of speech; e.g., which misarticulations are appropriate or inappropriate to the child's cognitive level. If a child is receiving treatment to remediate a speech impairment, the most likely source of this kind of information will be the speech-language pathologist. However, a preschool or special education teacher may also be able to provide the needed information, as might another health care specialist; e.g., developmental pediatrician, pediatric neurologist, occupational therapist, or a person otherwise qualified by training and experience.

E. *Duration.* Children who exhibit serious speech difficulties will sometimes ''outgrow'' them. Some speech difficulties will respond to treatment more readily than others. Therefore, when it is determined that a child has a ''marked'' limitation in cognition together with a ''marked'' limitation in speech that has not yet lasted at this level for 12 months, it will be necessary to determine whether the limitation in speech is expected to persist at the ''marked'' level for a continuous period of at least 12 months. The presence of any of the factors in Table 2 makes it less likely that the child will simply ''outgrow'' the speech impairment, and more likely that a longer period of intervention will be required for remediation of the speech impairment.

The presence of one of the factors in Table 2 will strongly suggest that an impairment has met or will meet the duration requirement. However, the converse is not necessarily true: A child's speech impairment may nevertheless still require extensive speech treatment for a long period of time even though none of the factors in Table 2 is present in the evidence. Whether the impairment has lasted or is expected to last for a continuous period of not less than 12 months is a judgment that must be made based on the evidence particular to each case.

TABLE 1.—GUIDELINES FOR EVALUATING SEVERITY OF SPEECH IMPAIRMENTS

Chronological age or cognitive level (see section VI.B.)	Marked limitation	Extreme limitation
Birth to attainment of 2 years	a. Sound production other than crying (e.g., cooing, babbling, jargoning) occurs infrequently; child is unusually quiet; or b. Limited or otherwise abnormal variation in pitch, intensity, and sound production	a. A criterion for Marked Limitation is met, and b. Consonant-vowel repertoire is not sufficient to support the development of expressive language.
2 to attainment of 3½ years	a. Most messages are not readily intelligible even in context; and b. Sounds, omissions, distortions, or phonological patterns, or fluency (rate, rhythm of speech) not typical for this group; or significant aberrations in vocal pitch, quality, or intensity	a. Criteria for Marked Limitation are met, and b. Gesturing and pointing are used most of the time instead of oral expression, and c. Intelligibility does not improve even with repetition or models, or ability to imitate words is limited.

[6] Although reference is made to the child's topic of conversation, which necessarily involves language, the issue being addressed here is the child's speech and its intelligibility in conversation; the topic of conversation is one of many variables that can affect the intelligibility of the child's speech for the listener.

TABLE 1.—GUIDELINES FOR EVALUATING SEVERITY OF SPEECH IMPAIRMENTS—Continued

Chronological age or cognitive level (see section VI.B.)	Marked limitation	Extreme limitation
3½ to attainment of 5 years	a. Sounds, omissions, distortions, or phonological patterns, or fluency (rate, rhythm of speech) not typical for this group; or significant aberrations in vocal pitch, quality, or intensity; and b. Conversation is intelligible no more than ½ of the time on first attempt; and c. Intelligibility improves with repetitions	a. Criteria a. and b. for Marked Limitation are met, and b. Conversation continues to be intelligible no more than 1/2 of the time despite repetitions and c. Stimulability for production of sounds is limited, or, ability to imitate words is limited.
5 years and older	a. Sounds, omissions, distortions, or phonological patterns, or fluency (rate, rhythm of speech) not typical for this group; or significant aberrations in vocal pitch, quality, or intensity; and b. Conversation is intelligible no more than ½ to ⅔ of the time on first attempt; and c. Intelligibility improves with repetitions	a. Sounds, omissions, distortions, or phonological patterns, or fluency (rate, rhythm of speech) not typical for this group; or significant aberrations in vocal pitch, quality, or intensity; and b. Conversation is intelligible no more than ½ of the time despite repetitions.

TABLE 2.—FACTORS SUGGESTING THAT THE DURATION REQUIREMENT WILL BE MET

1. Neurologically based abnormalities, including—
   - Oral-motor problems at the volitional level (e.g., ability to imitate oral-motor movements is limited); or
   - Oral-motor problems at the automatic level (e.g., drools profusely, exhibits feeding disorder); or
   - Oral hypersensitivity (e.g., limited tolerance of different food textures); or
   - Insufficient breath support for speech.
2. Hearing abnormalities, including—
   - Conductive hearing loss; or
   - Sensorineural hearing loss.
3. Structurally based abnormalities, including—
   - Defect of the oral mechanism (e.g., vocal fold paralysis); or
   - Oral-facial abnormality (e.g., cleft lip/palate).
4. Speech-related behavioral abnormalities, including—
   - Communication-related physical behaviors that are negative (e.g., grimaces or has excessive eye-blinking during stuttering episodes; gestures, such as slapping a surface, to end stuttering block); or
   - Avoidance of speaking because of speech difficulties.

EFFECTIVE DATE: This Ruling is effective March 30, 1998.

Cross-references: Program Operations Manual System DI 25201.001–005, DI 25215.005, DI 34001.000, DI 34005.000.

[FR Doc. 98–8135 Filed 3–27–98; 8:45 am]

BILLING CODE 4190–29–U

DEPARTMENT OF STATE

[Public Notice No. 2774]

Renewal of Defense Trade Advisory Group Charter and Notice of Meeting

The updated Charter of the Defense Trade Advisory Group has been renewed for a two-year period. The Charter was revised for clarification. The Defense Trade Advisory Group (DTAG) will meet beginning at 9 a.m. on Friday, April 17, 1998, in the East Auditorium, Room 2925, U.S. Department of State, 2201 C Street, NW, Washington, DC. The membership of this advisory committee consists of private sector defense trade specialists appointed by the Assistant Secretary of State for Political-Military Affairs who advise the Department on policies, regulations, and technical issues affecting defense trade.

The open session will include presentations by guest speakers and representatives of the Department of State and other agencies. Reports will also be presented on DTAG Working Group progress, results, and future projects.

Members of the public may attend the open session as seating capacity allows, and will be permitted to participate in the discussion in accordance with the Chairman's instruction.

As access to the Department of State is controlled, persons wishing to attend the meeting must notify the DTAG Executive Secretariat by COB Monday, April 13, 1998. If notified after this date, the DTAG Secretariat cannot guarantee that State's Bureau of Diplomatic Security can complete the necessary processing required to attend the April 17 plenary.

Each person should provide his/her name, company or organizational affiliation, date of birth, and social security number to the DTAG Secretariat by fax to (202) 647–4232 (Attention: Mike Slack). This information will be placed on a list for Diplomatic Security and the Reception Desk at the C-Street diplomatic entrance. Attendees must carry a valid photo ID with them. They should enter the building through the C-Street diplomatic entrance (22nd and C Streets, NW) where Department personnel will direct them to the security check point and on to the East auditorium.

A working lunch will be held at the Department. Limits on available seating may require attendance be limited only to DTAG members.

FOR FURTHER INFORMATION CONTACT: Mike Slack, DTAG Secretariat, U.S. Department of State, Office of Arms Transfer and Export Control Policy (PM/ATEC), Room 2422 Main State, Washington, DC 20520–2422. Phone: (202) 647–2882, fax (202) 647–4232.

Dated: March 20, 1998.

John P. Barker,

Deputy Assistant Secretary for Export Controls, Bureau of Political-Military Affairs.

[FR Doc. 98–8146 Filed 3–27–98; 8:45 am]

BILLING CODE 4710–25–M

DEPARTMENT OF TRANSPORTATION

Office of the Secretary

Reports, Forms and Recordkeeping Requirements; Agency Information Collection Activity Under OMB Review

AGENCY: Office of the Secretary, DOT.

ACTION: Notice.

SUMMARY: In compliance with the Paperwork Reduction Act 1995 (44 USC Chapter 35), this notice announces that the Information Collection Request (ICR) abstracted below has been forwarded to the Office of Management and Budget