inconsistencies that need to be resolved.[23]

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

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

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

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

At other times, an apparent inconsistency may not be a true inconsistency. For example, the record for a child with attention-deficit/hyperactivity disorder (AD/HD) may include good, longitudinal evidence of hyperactivity at home and in the classroom, but show a lack of hyperactivity during a CE. While this may appear to be an inconsistency, it is a well-known clinical phenomenon that children with some impairments (for example, AD/HD) may be calmer, less inattentive, or less out-of-control in a novel or one-to-one setting, such as a CE. *See* 20 CFR 416.924a(b)(6).[24]

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

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

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

Cross-References: SSR 09–1p, Title XVI: Determining Childhood Disability Under the Functional Equivalence Rule—The ''Whole Child'' Approach; SSR 09–3p, Title XVI: Determining Childhood Disability—The Functional Equivalence Domain of ''Acquiring and Using Information''; SSR 09–4p, Title XVI: Determining Childhood Disability—The Functional Equivalence Domain of ''Attending and Completing Tasks''; SSR 09–5p, Title XVI: Determining Childhood Disability—The Functional Equivalence Domain of ''Interacting and Relating with Others''; SSR 09–6p, Title XVI: Determining Childhood Disability—The Functional Equivalence Domain of ''Moving About and Manipulating Objects''; SSR 09–7p, Title XVI: Determining Childhood Disability—The Functional Equivalence Domain of ''Caring For Yourself''; SSR 09–8p, Title XVI: Determining Childhood Disability—The Functional Equivalence Domain of ''Health and Physical Well-Being''; SSR 06–03p, Titles II and XVI: Considering Opinions and Other Evidence from Sources Who Are Not ''Acceptable Medical Sources'' in Disability Claims; Considering Decisions on Disability by Other Governmental and Nongovernmental Agencies; and Program Operations Manual System (POMS) DI 24515.055, DI 25225.030, DI 25225.035, DI 25225.040, DI 25225.045, DI 25225.050, and DI 25225.055.

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

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

[25] With respect to testing, we provide in 20 CFR 416.926a(b)(4)(iii) that we will try to resolve material inconsistencies between test scores and other information in the case record. We explain that, while it is our responsibility to resolve any material inconsistencies, the interpretation of a test is ''primarily the responsibility of the psychologist or other professional who administered the test.'' If necessary, we may recontact the professional who administered the test for further clarification. However, we may also resolve an inconsistency with other information in the case record, by questioning other people who can provide us with information about a child's day-to-day functioning, or by purchasing a consultative examination. This regulation also provides that when we do not believe that a test score accurately indicates a child's abilities, we will document our reasons for not accepting the score in the case record, or in the decision at the administrative law judge hearing and Appeals Council levels (when the Appeals Council makes a decision).

SOCIAL SECURITY ADMINISTRATION

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

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

AGENCY: Social Security Administration.

ACTION: Notice of Social Security Ruling (SSR).

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

DATES: *Effective Date:* March 20, 2009.

FOR FURTHER INFORMATION CONTACT: Janet Truhe, Office of Disability Programs, Social Security Administration, 6401 Security Boulevard, Baltimore, MD 21235–6401, (410) 965–1020.

SUPPLEMENTARY INFORMATION: Although 5 U.S.C. 552(a)(1) and (a)(2) do not require us to publish this SSR, we are doing so under 20 CFR 402.35(b)(1).

SSRs make available to the public precedential decisions relating to the Federal old-age, survivors, disability, supplemental security income, special veterans benefits, and black lung benefits programs. SSRs may be based

on determinations or decisions made at all levels of administrative adjudication, Federal court decisions, Commissioner's decisions, opinions of the Office of the General Counsel, or other interpretations of the law and regulations.

Although SSRs do not have the same force and effect as statutes or regulations, they are binding on all components of the Social Security Administration. 20 CFR 402.35(b)(1).

This SSR will be in effect until we publish a notice in the **Federal Register** that rescinds it, or publish a new SSR that replaces or modifies it.

(Catalog of Federal Domestic Assistance, Program No. 96.006 Supplemental Security Income.)

Dated: February 9, 2009.

Michael J. Astrue,

Commissioner of Social Security.

Policy Interpretation Ruling Title XVI: Determining Childhood Disability—The Functional Equivalence Domain of ''Attending and Completing Tasks''

Purpose: This SSR consolidates information from our regulations, training materials, and question-and-answer documents about the functional equivalence domain of ''Attending and completing tasks.'' It also explains our policy about that domain.

Citations: Sections 1614(a)(3), 1614(a)(4), and 1614(c) of the Social Security Act, as amended; Regulations No. 4, subpart P, appendix 1; and Regulations No. 16, subpart I, sections 416.902, 416.906, 416.909, 416.923, 416.924, 416.924a, 416.924b, 416.925, 416.926, 416.926a, and 416.994a.

Introduction: A child [1] who applies for Supplemental Security Income (SSI) [2] is ''disabled'' if the child is not engaged in substantial gainful activity and has a medically determinable physical or mental impairment or combination of impairments [3] that results in ''marked and severe functional limitations.'' [4] 20 CFR 416.906. This means that the impairment(s) must *meet* or *medically equal* a listing in the Listing of Impairments (the listings) [5] or *functionally equal* the listings (also referred to as ''functional equivalence''). 20 CFR 416.924 and 416.926a.

As we explain in greater detail in SSR 09–1p, we always evaluate the ''whole child'' when we make a finding regarding functional equivalence, unless we can otherwise make a fully favorable determination or decision.[6] We focus first on the child's activities, and evaluate how appropriately, effectively, and independently the child functions compared to children of the same age who do not have impairments. 20 CFR 416.926a(b) and (c). We consider what activities the child cannot do, has difficulty doing, needs help doing, or is restricted from doing because of the impairment(s). 20 CFR 416.926a(a). *Activities* are everything a child does at home, at school, and in the community, 24 hours a day, 7 days a week.[7] We next evaluate the effects of a child's impairment(s) by rating the degree to which the impairment(s) limits functioning in six ''domains.'' *Domains* are broad areas of functioning intended to capture all of what a child can or cannot do. We use the following six domains:

(1) Acquiring and using information,

(2) Attending and completing tasks,

(3) Interacting and relating with others,

(4) Moving about and manipulating objects,

(5) Caring for yourself, and

(6) Health and physical well-being.

20 CFR 416.926a(b)(1).[8]

To functionally equal the listings, an impairment(s) must be of listing-level severity; that is, it must result in ''marked'' limitations in two domains of functioning or an ''extreme'' limitation in one domain.[9] 20 CFR 416.926a(a).

Policy Interpretation

General

In the domain of ''Attending and completing tasks,'' we consider a child's ability to focus and maintain attention, and to begin, carry through, and finish activities or tasks. We consider the child's ability to initiate and maintain attention, including the child's alertness and ability to focus on an activity or task despite distractions, and to perform tasks at an appropriate pace. We also consider the child's ability to change focus after completing a task and to avoid impulsive thinking and acting. Finally, we evaluate a child's ability to organize, plan ahead, prioritize competing tasks, and manage time.[10]

The ability to attend and to complete tasks develops throughout childhood, evolving from an infant's earliest response to stimuli, such as light, sound, and movement, to an adolescent's completion of academic requirements. Over time, this evolution can be seen in the steady development of a child's ability to attend and to complete increasingly complex tasks. For example:

- Newborns or young infants gaze at human faces or moving objects, and listen in the direction of a human voice.
- Toddlers engage in activities that interest them, such as listening to a story.

[1] The definition of disability in section 1614(a)(3)(C) of the Social Security Act (the Act) applies to any ''individual'' who has not attained age 18. In this SSR, we use the word ''child'' to refer to any such person, regardless of whether the person is considered a ''child'' for purposes of the SSI program under section 1614(c) of the Act.

[2] For simplicity, we refer in this SSR only to initial claims for benefits. However, the policy interpretations in this SSR also apply to continuing disability reviews of children under section 1614(a)(4) of the Act and 20 CFR 416.994a.

[3] We use the term ''impairment(s)'' in this SSR to refer to an ''impairment or a combination of impairments.''

[4] The impairment(s) must also satisfy the duration requirement in section 1614(a)(3)(A) of the Act; that is, it must be expected to result in death, or must have lasted or be expected to last for a continuous period of not less than 12 months.

[5] For each major body system, the listings describe impairments we consider severe enough to cause ''marked and severe functional limitations.'' 20 CFR 416.925(a); 20 CFR part 404, subpart P, appendix 1.

[6] *See* SSR 09–1p, Title XVI: Determining Childhood Disability Under the Functional Equivalence Rule—The ''Whole Child'' Approach.

[7] However, some children have chronic physical or mental impairments that are characterized by episodes of exacerbation (worsening) and remission (improvement); therefore, their level of functioning may vary considerably over time. To properly evaluate the *severity* of a child's limitations in functioning, as described in the following paragraphs, we must consider any variations in the child's level of functioning to determine the impact of the chronic illness on the child's ability to function longitudinally; that is, over time. For more information about how we evaluate the severity of a child's limitations, *see* SSR 09–1p. For a comprehensive discussion of how we document a child's functioning, including evidentiary sources, *see* SSR 09–2p, Title XVI: Determining Childhood Disability—Documenting a Child's Impairment-Related Limitations.

[8] For the first five domains, we describe typical development and functioning using five age categories: Newborns and young infants (birth to attainment of age 1); older infants and toddlers (age 1 to attainment of age 3); preschool children (age 3 to attainment of age 6); school-age children (age 6 to attainment of age 12); and adolescents (age 12 to attainment of age 18). We do not use age categories in the sixth domain because that domain does not address typical development and functioning, as we explain in SSR 09–8p, Title XVI: Determining Childhood Disability—The Functional Equivalence Domain of ''Health and Physical Well-Being.''

[9] *See* 20 CFR 416.926a(e) for definitions of the terms ''marked'' and ''extreme.''

[10] In 20 CFR 416.924a(b)(5), we provide that how independently a child can ''initiate, sustain, and complete'' activities is a ''factor'' we consider when evaluating a child's functioning. The difference between this ''factor'' and the domain of ''Attending and completing tasks'' is that the factor addresses the issue of independence in functioning at every step in the sequential evaluation process and in all domains—the extent to which a child can begin, carry out, and finish age-appropriate activities at an appropriate rate and without needing extra help. The child may receive help in a number of ways: Personal service from another person; special equipment, devices, or medications; adaptations (such as special appliances); and structured or supportive settings, including the amount of help the child needs to remain in a regular setting. The domain of ''Attending and completing tasks'' assesses a child's specific ability to focus and maintain attention.

• Preschool children engage in uninterrupted periods of play, such as putting a puzzle together.

• School-age children focus long enough to do classwork and homework.

• Adolescents may perform part-time work requiring sustained attention to assigned duties that must be completed on time.

As in any domain, when we evaluate a child's limitations in the domain of ''Attending and completing tasks,'' we consider how appropriately, effectively, and independently the child functions compared to children of the same age who do not have impairments. For example, a teacher may report that a child ''pays attention well with frequent prompting.'' The need for frequent prompting demonstrates that the child is not paying attention as appropriately, effectively, or independently as children of the same age who do not have impairments. Despite the fact that the child is paying attention with prompting, this child is not functioning well in this domain.

The domain of ''Attending and completing tasks'' covers only the mental aspects of task completion; such as the mental pace that a child can maintain to complete a task.[11] Therefore, limitations in the domain of ''Attending and completing tasks'' are most often seen in children with mental disorders. For example, in school:

• Children with attention-deficit/hyperactivity disorder (AD/HD) whose primary difficulty is *inattention* may be easily distracted or have difficulty focusing on what is important and staying on task. They may fail to pay close attention to details and make careless mistakes in schoolwork, avoid projects that require sustained attention, or lose things needed for school or other activities beyond what is expected of children their age who do not have impairments.

• Children with AD/HD whose primary difficulty is *hyperactivity* and *impulsivity* may fidget with objects instead of paying attention, talk instead of listening to instructions, or get up from their desks and wander around the classroom beyond what is expected of children their age who do not have impairments.[12]

Although we more often see limitations in this domain in connection with mental disorders, a physical impairment(s) can also affect a child's mental ability to attend and to complete tasks. For example, pain caused by a musculoskeletal disorder can distract a child and interfere with the child's ability to concentrate and to complete assignments on time. Medications that affect concentration or interfere with other mental processes, such as some medications for seizure disorders, may also affect a child's ability to attend and to complete tasks.

Some children with impairments can attend to some tasks, but not to all tasks in all settings. Such children may exhibit ''hyperfocus,'' an intense focus on things that interest them, such as video games, but be limited in their ability to focus on other tasks. These kinds of limitations in the domain of ''Attending and completing tasks'' are common in children with AD/HD and autistic spectrum disorders (ASD). For example, some children with ASD may be distracted by, or become fixated on, everyday sounds (such as the hum of an air conditioner) that children without impairments can easily ignore. Children with autism may become fixated on parts of an object (such as the wheels on a toy truck) rather than on the more obvious and primary use of the object. Children with Asperger's disorder (one type of ASD), may hyperfocus on a single area of interest and have difficulty discussing or paying attention to any other subject. These children may appear to function well, or even better than other children, in the area of hyperfocus, but may be very limited in some other tasks and settings.

As with limitations in any domain, we do not consider a limitation in the domain of ''Attending and completing tasks'' unless it results from a medically determinable impairment(s). However, while it is common for all children to experience some difficulty attending and completing tasks from time to time, a child who has significant but unexplained problems in this domain may have an impairment(s) that was not alleged or has not yet been diagnosed. In such cases, adjudicators should pursue any indications that an impairment(s) may be present.

Effects in Other Domains

In the domain of ''Attending and completing tasks,'' we consider the mental aspects of a child's ability to focus, maintain attention, and complete age-appropriate tasks throughout the day. In addition, because the ability to attend and to complete tasks is involved in nearly everything a child does, an impairment(s) that affects this ability may cause limitations in other domains.

For example, school-age children with AD/HD may have limitations in multiple domains. The effects of inattention and hyperactivity can impede the learning process and affect competence in many areas of life. These effects can result in limitations in the domain of ''Acquiring and using information''; for example, by undermining academic performance. They may also have effects in the domain of ''Interacting and relating with others''; for example, children with AD/HD may interrupt others in conversation or have difficulty taking turns during play activities. They may also cause limitations in the domain of ''Caring for yourself''; for example, when a child risks personal safety by not stopping and thinking before doing something.

Therefore, as in any case, we evaluate the effects of a child's impairment(s), including the effects of medication or other treatment and therapies, in all relevant domains. Rating the limitations caused by a child's impairment(s) in each and every domain that is affected is *not* ''double-weighting'' of either the impairment(s) or its effects. Rather, it recognizes the particular effects of the child's impairment(s) in all domains involved in the child's limited activities.[13]

Examples of Typical Functioning in the Domain of ''Attending and Completing Tasks''

While there is a wide range of normal development, most children follow a typical course as they grow and mature. To assist adjudicators in evaluating a child's impairment-related limitations in the domain of ''Attending and completing tasks,'' we provide the following examples of typical functioning drawn from our regulations, training, and case reviews. These examples are not all-inclusive, and

[11] We evaluate a child's *physical* ability to complete tasks in the domain of ''Moving about and manipulating objects,'' or when appropriate, ''Health and physical well-being.'' For example, a child who has difficulty getting dressed at an age-appropriate pace because of rheumatoid arthritis has a limitation that we evaluate in the domain of ''Moving about and manipulating objects'' or ''Health and physical well-being'' depending on the specific physical reason for the limitation; for example, joint deformity (Moving about and manipulating objects) or constitutional symptoms and signs (Health and physical well-being). A physical impairment may have effects that we evaluate in both the domains of ''Moving about and manipulating objects'' and ''Health and physical well-being''; such as when a child has both a musculoskeletal deformity and constitutional symptoms and signs because of systemic sclerosis. In addition to the SSRs for the other domains cited at the end of this SSR, *see* generally SSR 09–1p.

[12] We provide a number of examples involving AD/HD and autism spectrum disorders in this SSR because these impairments frequently occur in childhood SSI cases. However, many other kinds of mental disorders can cause limitations in the ability to attend and to complete tasks. For example, mood disorders, such as depression, often cause difficulties in concentration.

[13] For more information about how we rate limitations, including their interactive and cumulative effects, *see* SSR 09–1p.

adjudicators are not required to develop evidence about each of them. They are simply a frame of reference for determining whether children are functioning typically for their age with respect to attending and completing tasks.

1. Newborns and Young Infants (Birth to Attainment of Age 1)

- Shows sensitivity to environment by responding to various stimuli (for example, light, touch, temperature, movement).
- Stops activity when voices or other sounds are heard.
- Begins to notice and gaze at various moving objects, including people and toys.
- Listens to family conversations and plays with people and toys for progressively longer periods of time.
- Wants to change activities frequently, but gradually expands interest in continuing an interaction or a game.

2. Older Infants and Toddlers (Age 1 to Attainment of Age 3)

- Attends to things of interest (for example, looking at picture books, listening to stories).
- Has adequate attention to complete some tasks independently (for example, putting a toy away).
- Demonstrates sustained attention (for example, building with blocks, helping to put on clothes).

3. Preschool Children (Age 3 to Attainment of Age 6)

- Pays attention when spoken to directly.
- Sustains attention to play and learning activities.
- Concentrates on activities like putting puzzles together or completing art projects.
- Focuses long enough to complete many activities independently (for example, getting dressed, eating).
- Takes turns and changes activities when told by a caregiver or teacher that it is time to do something else.
- Plays contentedly and independently without constant supervision.

4. School-age Children (Age 6 to Attainment of Age 12)

- Focuses attention in a variety of situations in order to follow directions, completes school assignments, and remembers and organizes school-related materials.
- Concentrates on details and avoids making careless mistakes.
- Changes activities or routines without distracting self or others.
- Sustains attention well enough to participate in group sports, read alone, and complete family chores.
- Completes a transition task without extra reminders or supervision (for example, changing clothes after gym or going to another classroom at the end of a lesson).

5. Adolescents (Age 12 to Attainment of Age 18)

- Pays attention to increasingly longer presentations and discussions.
- Maintains concentration while reading textbooks.
- Plans and completes long-range academic projects independently.
- Organizes materials and manages time in order to complete school assignments.
- Maintains attention on tasks for extended periods of time, and is not unduly distracted by or distracting to peers in a school or work setting.

Examples of Limitations in the Domain of ''Attending and Completing Tasks''

To further assist adjudicators in evaluating a child's impairment-related limitations in the domain of ''Attending and completing tasks,'' we also provide the following examples of some of the limitations we consider in this domain. These examples are drawn from our regulations and training. They are not the only examples of limitations in this domain, nor do they necessarily describe a ''marked'' or an ''extreme'' limitation.

In addition, the examples below may or may not describe limitations depending on the expected level of functioning for a given child's age. For example, a toddler would not be expected to be able to play a game or stay on another task for an hour, but a teenager would.[14]

- Is easily startled, distracted, or overreactive to everyday sounds.
- Is slow to focus on or fails to complete activities that interest the child.
- Gives up easily on tasks that are within the child's capabilities.
- Repeatedly becomes sidetracked from activities or frequently interrupts others.
- Needs extra supervision to stay on task.
- Cannot plan, manage time, or organize self in order to complete assignments or chores.

Effective date: This SSR is effective upon publication in the **Federal Register**.

Cross-References: SSR 09–1p, Title XVI: Determining Childhood Disability under the Functional Equivalence Rule—The ''Whole Child'' Approach; SSR 09–2p, Title XVI: Determining Childhood Disability—Documenting a Child's Impairment-Related Limitations; SSR 09–3p, Title XVI: Determining Childhood Disability—The Functional Equivalence Domain of ''Acquiring and Using information''; SSR 09–5p, Title XVI: Determining Childhood Disability—The Functional Equivalence Domain of ''Interacting and Relating with Others''; SSR 09–6p, Title XVI: Determining Childhood Disability—The Functional Equivalence Domain of ''Moving About and Manipulating Objects''; SSR 09–7p, Title XVI: Determining Childhood Disability—The Functional Equivalence Domain of ''Caring for Yourself''; SSR 09–8p, Title XVI: Determining Childhood Disability—The Functional Equivalence Domain of ''Health and Physical Well-Being''; SSR 98–1p, Determining Medical Equivalence in Title XVI Childhood Disability Claims When a Child Has Marked Limitations in Cognition and Speech; and Program Operations Manual System (POMS) DI 25225.030, DI 25225.035, DI 25225.040, DI 25225.045, DI 25225.050, and DI 25225.055.

[14] *See* 20 CFR 416.924b.

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DEPARTMENT OF TRANSPORTATION

Federal Aviation Administration

Supplemental Notice of Meeting of the National Parks Overflights Advisory Group Aviation Rulemaking Committee

ACTION: Revised notice of meeting and additional information.

SUMMARY: The Federal Aviation Administration (FAA) and the National Park Service (NPS), in accordance with the National Parks Air Tour Management Act of 2000, announce the next meeting of the National Parks Overflights Advisory Group (NPOAG) Aviation Rulemaking Committee (ARC). This notification provides the date, format, and agenda for the meeting and provides additional information to the **Federal Register** notice published on February 3, 2009 (Vol. 74, No. 21, Page 5969) by providing the call in number for the public to access the telcon.

Dates and Location: The NPOAG ARC will hold a meeting on February 25th, 2009. The meeting will be conducted as a telephone conference call. The meeting will be held from 9 a.m. to 12 p.m. Pacific Standard Time on February 25th. This NPOAG meeting will be open