

was positive for HIV, an immune system disorder.

4. The petitioner was referred to the clinic of a teaching hospital where a specialist in immunology, and doctors working with him, have continued to monitor the petitioner's medical condition since December of 1988.

5. Serology and other tests done by the teaching clinic in December of 1988 confirmed the HIV positive diagnosis. At that time, the petitioner's only symptoms were the mouth infection, a cold, and nodules on her vocal chords. She was treated for these problems and, it was her doctor's opinion, that though her blood tests showed a lowered resistance to infection, she was not at or near a dangerously critical level of immune suppression.

6. The petitioner had blood tests on March 13, 1989, and was examined on March 20, 1989, with the resultant conclusion that the petitioner's immunodeficiency had not progressed significantly. She still suffered from oral thrush and had contracted a vaginal yeast infection. In addition, several small cervical nodes were noted and her skin was found to be dry and scaly.

7. In late March of 1989, the petitioner reported to DSW that she was not able to work full-time and did not know how much longer she could even continue her part-time work.

She never specified what this work was.¹ Her part-time salary was consumed by health insurance payments of \$138.00

per month (which would not cover her condition for 12 more months), prescriptions of \$200 - \$300 per month, and doctors' bills.

8. Blood tests performed on April 19, 1989 showed that the petitioner's immune levels had plunged dramatically in the last month. She was tested again and examined by her treating specialist on May 15, 1989, where it was found that her immune levels had dropped to a critical level and it was determined that AZT treatment would begin to attempt to prevent further deterioration of her immune system and development of more serious infections. At that point, in addition to her various yeast infections, the petitioner was also suffering from increased fatigue, headaches, diarrhea, weight loss, more significantly swollen glands and depression. Her falling lymphocyte count in conjunction with her worsened symptoms caused her physician to conclude that she showed "clear manifestations of progressive HIV infection" which would render her "unable to carry out full time work at the present time". He also noted "that she is becoming symptomatic and disabled with her HIV infection."

9. In July of 1989, a colleague of the petitioner's treating physician who also specializes in infectious diseases, stated that the petitioner has "AIDS" based on her HIV test, lowered lymphocyte levels, fatigue, fevers, severe headaches, severe nausea and vomiting. It was his opinion that her condition had lasted over 6 months, would last forever and would prevent her from working any jobs during

the next twelve months.

10. In August of 1989, the petitioner's treating specialist stated that she had an HIV infection with lowered blood count, attendant oral candidiasis, and depression for which she was continuing to be treated with AZT and several other medications, including tranquilizers. It was his opinion that her fatigue was due to her infection and associated depression and would cause her to be unable to perform her previous or any work for the next twelve months or more. He further stated that "this [HIV infection] will last lifelong with probable progression to some AIDS related disorder unless some more effective treatment is developed."

11. Based on the above evidence, it is further found that as of July 10, 1989, her immune system dysfunction and resultant infections caused her severe fatigue and depression which significantly interfered with her ability to sustain basic work activities either full time or part time and that her inability to sustain these activities is expected to continue at least 12 months, and probably indefinitely, into the future. This finding assumes that the petitioner was no longer engaged in substantial gainful activity on July 10, 1989.

ORDER

The petitioner is found to be disabled as of July 10, 1989.

REASONS

Medicaid Manual Section M211.2 defines disability as follows:

Disability is the inability to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment, or combination of impairments, which can be expected to result in death or has lasted or can be expected to last for a continuous period of not fewer than twelve (12) months. To meet this definition, the applicant must have a severe impairment, which makes him/her unable to do his/her previous work or any other substantial gainful activity which exists in the national economy. To determine whether the client is able to do any other work, the client's residual functional capacity, age, education, and work experience is considered.

It is the policy of the Social Security Administration to find persons who are diagnosed as having Acquired Immune Deficiency Syndrome (AIDS) as being presumptively disabled.

See attached Program Policy Statement, PPS-111, (July 1984). Although one physician described the petitioner as suffering from AIDS, the petitioner did not suffer from a serious opportunistic infection (see list) which would justify such a diagnosis.

That being the case, the petitioner's diagnosis, HIV infection, and resultant symptoms must be assessed as to their severity and duration based on the medical and other evidence. Although the petitioner did not herself testify, the evidence does show that she was working in late March and there is no reason to believe that her work, though part time was not substantial and gainful. Her symptoms worsened by mid-May but there is nothing in the evidence to suggest their effect on her work abilities other than that she did

not have the stamina for full-time work. There is nothing to suggest that she could not continue her part-time work.

By July 10, however, there is credible medical evidence that the petitioner's symptoms had become so severe that she could do no work. That opinion was corroborated by the August 1989 opinion of her treating physician. As the petitioner's ability to sustain any work activities was seriously compromised by July 10, it must be concluded that her conditions in combination equaled the severity and duration of the listings of impairments at 20 C.F.R. § 404, Appendix 1, Subpart P as of that date. See C.F.R. § 404, 1520(d).

FOOTNOTES

¹The petitioner chose not to appear at the hearing so further information on some points could not be elicited.

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