Statement

Presented by

The National Association of Disability Examiners

Jennifer Nottingham, President

Presented to the

Committee on Oversight and Government Reform

Subcommittee on Energy Policy, Health Care and Entitlements

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Mr. Chairman, Members of the Subcommittee on Energy Policy, Health Care and Entitlements, Committee on Oversight and Government Reform. My name is Jennifer Nottingham and I am the current President of NADE, the National Association of Disability Examiners. I am also a Supervisor in the Ohio Disability Determination Service, or DDS. The members of NADE thank you for this opportunity to offer our comment and insight regarding the Social Security Administration's management of the federal disability programs. This hearing will examine the effectiveness of SSA's current process to medically review beneficiaries to determine if they should continue to receive federal disability benefits.

Who We Are

NADE is a professional association whose purpose is to promote the art and science of disability evaluation. The majority of our members work in the state Disability Determination Service (DDS) agencies where 15,000+ employees adjudicate claims for Social Security and/or Supplemental Security Income (SSI) disability benefits. As such, our members constitute the "front lines" of disability evaluation. Our membership also includes many SSA Central and Regional Office personnel, attorneys, physicians, non-attorney claimant representatives, and claimant advocates. The diversity of our membership, combined with our extensive program knowledge and "hands on" experience, enables NADE to offer a perspective on disability issues that is unique and which reflects a programmatic realism, which we believe, is a critical factor for Members of this Subcommittee to consider.

NADE members are deeply concerned about the integrity and efficiency of the Social Security and the SSI disability programs. Simply stated, we believe those who are entitled to disability benefits under the law should receive them; those who are not, should not.

The CDR Claims Process and Impact of MIRS

When a claim is approved for disability benefits, a diary is established for that claim to be reviewed again after a certain period, usually three (3) to seven (7) years, to determine if the disabling condition continues. After the diary expires, the claim is sent to the DDS for a Continuing Disability Review (CDR). The Medical Improvement Review Standard (MIRS) is used to evaluate CDR claims. MIRS was established in 1984 after a mandate from Congress. The MIRS policy dictates that benefits continue unless the beneficiary's disabling condition has shown medical improvement and the medical improvement is related to the ability to work. In effect, MIRS turns the tables on the federal disability program. During the initial application process, the burden is on the claimant to prove they are disabled. For initial and reconsideration claims, SSA defines disability as the inability to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death, or has lasted for a continuous period of not less than 12 months. At the CDR level, the necessity to apply MIRS shifts the burden to SSA and the Disability Determination Service (DDS) to prove there has been significant medical improvement related to the ability to work. The MIRS standard is very stringent and, as a result, few claims are actually ceased. It must be noted, when the DDS proposes a cessation of benefits for CDRs or Age 18 redeterminations, the decision is not always upheld on subsequent appeal by Disability Hearing Officers (DHO) or Administrative Law Judges (ALJ). The majority of cessations processed by the DDSs are the age 18 redeterminations. These are claims processed for adults who have recently attained the age of 18 and were allowed benefits as children. These claims are re-examined by the DDS using adult criteria to determine if disability continues. MIRS does not apply to age 18 redeterminations. Instead, the DDS makes a new initial determination whether the claimant has an impairment that continues to be disabling based on adult criteria.

To process a CDR claim, the disability examiners are required to compare a beneficiary's current condition to the beneficiary's condition at the time of the most recent medical decision, whether that is the initial allowance decision or the most recent CDR continuance decision. This most recent favorable decision is called the Comparison Point Decision (CPD). Because of MIRS, the DDS can only fix a mistake on a prior allowance decision if there is a clear objective error on the previous decision, as the DDS is not allowed to substitute judgment. It is not unusual to find a CDR claim where the disability examiner would not currently find the beneficiary disabled, but must continue benefits because significant medical improvement cannot be shown. If an individual is allowed and had minimal abnormal findings at the CPD, as long as the findings are similar, the beneficiary will remain on the disability rolls.

Fraud or Similar Fault

A finding of fraud or similar fault would be an exception to the use of the MIRS. When fraud or similar fault is suspected on a claim, it can be referred to the Cooperative Disability Investigation Unit (CDIU), if it is available in the state. After screening by CDIU, the claim can then be sent to the Office of Inspector General (OIG). Once a Report of Investigation (ROI) is

completed, the DDS is able to make a decision with additional information to address the concerns with fraud or similar fault. Unfortunately, not all DDSs have access to a CDIU. In those states, a screening process involves multiple levels of management reviewing the claims where fraud is suspected to make a decision whether to refer the claim to OIG. Significantly fewer claims are referred to OIG from states without a CDIU. The majority of CDIU referrals are for initial or reconsideration claims. Only a small number of CDR claims are referred to OIG.

NADE believes it would be beneficial to the disability trust fund if there were an increased emphasis on referring CDR claims where fraud or similar fault is suspected, to CDIU. NADE supports the continued expansion of CDIUs and recommends each state have access to a CDIU. There are currently only 25 CDIUs in 22 states. To help with fraud detection, DDS employees should have access to more current employment information for claimants. NADE also supports a revision of the policies regarding fraud and similar fault. The current policies contain limited detail and direction on handling complex fraud or similar fault cases. NADE believes additional training in detecting and handling claims with suspicions of fraud or similar fault cases is always beneficial.

While any amount of fraud or similar fault is too much, fraud and similar fault is only involved in a small portion of the claims processed. Most claims where an individual may be inappropriately receiving disability benefits are due to judgments not supported by the evidence at the previous decision. In these cases, the CDR review of the CPD file shows too much weight was given to an unsupported medical source statement or the claimant's statements were found fully credible even though the statement was inconsistent with other evidence. It is important to distinguish these claims that seemingly are "mistakes" with judgments that are not supported by the evidence from claims where there was fraud or similar fault or a clear objective error made. In claims where judgments are not supported by the evidence, neither the fraud and similar fault nor the error exceptions to MIRS would apply and the examiner would need to make a determination if there was significant medical improvement related to the ability to work.

Exceptions to MIRS

There are exceptions to MIRS; the exceptions policy explains the limited situations where disability may be ceased without consideration of whether there is medical improvement. The intent of the exceptions policy is only to address situations where an individual clearly should never have been found disabled at CPD. There are two types of exceptions, Group I and Group II. These are defined for the DDSs in POMS DI 28020.001 through DI 28020.900. The Group II exceptions are fraud or similar fault, failure to cooperate, whereabouts unknown and failure to follow prescribed treatment. The Group II exceptions are commonly used in the DDS, particularly failure to cooperate. The Group I exceptions include vocational therapy; new or improved diagnostic or evaluative techniques; and error exceptions. The Group I exceptions are not generally well understood and, as a result, are rarely utilized in the DDS. Most disability examiners receive minimal, if any, training on the Group I exceptions to MIRS. It is important to note, the policy regarding the exceptions to MIRS is explicit that the exceptions should not be

used to substitute judgment. Disability Examiners aware of the policy on exceptions are often reluctant to utilize it due to an expectation of additional scrutiny by quality assurance reviewers either in the DDS or in the federal reviewing components. If the rationale for using an exception is not well documented, any attempt to apply an exception will be reversed on appeal.

The error exception is appropriate when the CPD evidence shows there was a clear error based upon the record. The only evidence that can be considered to determine if this exception applies is evidence on record at the time of the CPD decision. An error would have to be a clear objective finding that was incorrect. Examples would be the use of a vocational rule that did not apply or using medical records for the wrong patient. It would not be appropriate to use the error exception because the CDR decision maker came to a different conclusion than the CPD decision maker. Generally, disability allowances that are considered "inappropriate" or "in error" are actually not errors but rather, differences in the subjective findings of credibility and weighing of medical source statements. Indicating there was an error on a subjective finding would be substituting judgment, which is not allowed by the policy. While there would be some benefit to increased training on the exceptions to MIRS, using these exceptions would be rare as the policy applies to a limited number of claims.

Subjective Conclusions

The high allowance rates of some Administrative Law Judges (ALJs) have received significant attention. While fraud and error may be assumed to be the reason for high allowance rates, it is possible that fraud or error is not the cause in most claims. The higher allowance rate is more likely due to a difference in subjective judgments or decisions based on limited information. Subjective judgments are completed in the assessment of credibility and the weighing of medical source statements. In reviewing disability claims, there is the assumption that the claimant's statements are fully credible. Even so, the totality of the evidence needs to be considered to determine if the statements are consistent with the rest of the evidence in file, functioning and the claimant's medically determinable impairment. Similarly, if a treating source give a medical source opinion, it should be given controlling weight, but only if the statements are supported, consistent with other findings and would reasonably result from the impairment. If not, then the medical statements should be given less weight. The assessment of credibility and weighing of medical source opinions can have a large impact on the outcome of a claim. It would not be appropriate to use the error exception to MIRS on a claim just because the findings were not supported.

Case Scenarios

It may be best to illustrate the difference in fraud or similar fault, errors and a subjective conclusion through examples. Below are three examples of a claim being considered for an intellectual disability. When evaluating for this condition, a critical aspect is the adaptive functioning. While the IQ score is required, the individual's adaptive functioning should be consistent.

In one scenario, school records were not available and a consultative examination was completed. The claimant knowingly provided inaccurate answers so that the test scores underestimated their true intellectual abilities. The individual gave statements to the examiner, indicating they had many challenges completing activities of daily living independently. The claimant was awarded benefits because the IQ scores were in the mental retardation range and the claimant's report of functioning was consistent with a diagnosis of mental retardation. At CDR, if evidence was found that proved the individual knowingly provided inaccurate information, a finding of fraud or similar fault can be found. The MIRS exception for fraud or similar fault would apply.

In a second scenario, an individual provides information about their activities of daily living and reports that he attended special education classes in school. The examiner contacts the school and receives records with IQ testing in the mental retardation range; however, the records were for a different student. The examiner approved disability benefits based mainly upon the IQ scores. At CDR, the error exception would apply because the decision was clearly made based upon incorrect evidence. This would not be a case of fraud or similar fault because the individual did not provide inaccurate information.

In a third scenario, the individual received special education services while in school. The school records included an abbreviated intelligence test, which cannot be accepted by SSA for a measure of intelligence. The school testing indicated the student performed in the Borderline Intellectual Functioning range. The clmt attended a consultative exam and completed IQ testing, with scores that ranged from the Borderline Intellectual Functioning range to the Mental Retardation range. The CE examiner gave a diagnosis of Mental Retardation. Activities of daily living showed the claimant was able to drive and shop independently, complete household chores but had problems reading and needed help completing applications and forms. The examiner allowed the claim. On CDR, the current examiner finds that the school records and high level of functioning established in the activities of daily living are more consistent with a diagnosis of Borderline Intellectual Functioning rather than Mental Retardation and felt the initial decision should have been a denial. The MIRS exception would not apply as no clear error is shown at the initial decision. Instead, the difference is due to a difference in subjective conclusions. The initial examiner gave great weight to the diagnosis of the CE examiner, while the CDR examiner considered the diagnosis not consistent with the school records and the high level of functioning. It would be a substitution of judgment to conclude that the initial decision was wrong. MIRS would apply and disability benefits would continue if the beneficiary's activities of daily living were similar to the time of the initial decision.

Increased Efforts for Consistency Between DDSs and ALJs

NADE applauds SSA's recent efforts to bring consistency between the DDS and ALJ determinations. There has been improvement in documentation of rationales at the DDS level with the eCAT tool. SSA has recently focused on providing additional policy and medical training for ALJs. The result has been a decrease in the overall allowance rates by ALJs. While

the focus of this hearing is CDRs and MIRS, the ultimate goal is to have only the appropriate people receiving disability benefits. When the initial decision is correctly documented with a well-supported rationale, there is no "mistake" to address in the CDR.

When a claimant appeals a denial decision to the ALJ, they have the right to be represented at the hearing. NADE concurs with the right of claimants to be represented, as this is a privilege granted under our country's system of justice. However, that system of justice is also predicated on the concept that both parties to a dispute are represented at a hearing before an impartial third party. Such is not the case in disability hearing. Once the DDS makes its decision, it is left to stand on its own and can be interpreted by the ALJ in whatever manner they wish to interpret that decision. While a claimant is usually represented by counsel at a hearing, there is no one present to explain the DDS decision to the ALJ. The ALJ must review the claim file without benefit of talking to the decision maker or the DDS who can explain the basis for the decision. NADE believes it would be beneficial to have the DDS represented at the ALJ level.

Likewise, NADE believes there should be equal quality review for decisions made at all levels in the adjudicative process. Currently, 50% of DDS initial and reconsideration allowance decisions are subject to quality reviews by the federal reviewing component (DQBs). There are limited quality reviews for denial and CDR decisions and even fewer quality reviews of decisions made by Disability Hearing Officers and Administrative Law Judges. For the DDS examiners, because of the higher likelihood of initial allowance claims to be reviewed for quality assurance, there is a tendency to better document and rationalize allowance claims. An ALJ decision is typically only reviewed and questioned if there is an appeal of a denial decision. Consequently, it is more often found that ALJ denial decisions have more detailed rationales than allowance decisions. NADE believes it is critical for consistency of decision-making that more of the decisions made by DHOs and ALJs are subject to some type of quality review that will provide feedback to the decision maker.

Impact of Reductions in Workforce

In recent years, Congress has significantly reduced the budget for most federal agencies. SSA was not immune to these cutbacks, but the impact may have been particularly acute for SSA because the budget reductions coincided with heavy attrition due to massive retirements. The DDSs experienced attrition rates as high as 15% annually prior to the downturn in the economy and 10% after the downturn.

With a high attrition rate and hiring freezes, many states have experienced significant challenges in maintaining sufficient staff to process their workload. Unfortunately, the reduction in workforce coincided with an increase in initial claim filings of 15% annually following the economic downturn. SSA and the DDSs prioritized the initial claim workload and delayed the processing of CDRs until a time when adequate staff and resources were available. This delay in processing CDRs resulted in 1.3 million CDRs with overdue diaries.

SSA is attempting to correct this problem with the new budget funds. DDSs have been authorized to hire 2600 new personnel. New staff will help fill many of the positions in the DDSs that have been vacant, but it is necessary to stress that these 2600 new hires will not replace all vacant positions. In addition, while the new hiring authorization is welcome in the DDS community, obtaining clearance from state governments and other required personnel actions will make it challenging, if not impossible, for all new hires to be in place before the end of the fiscal year. In effect, some DDSs will not be able to hire for all positions they are authorized to hire for, as they will not be able to act as quickly as needed to fill all positions before funding authorization expires.

NADE wants to point out that SSA has done an excellent job sending age 18 redeterminations to the DDSs in a timely manner. There is a much higher likelihood of benefits ceasing with an age 18 redetermination since MIRS is not used. While the redeterminations were prioritized to be sent for review, other types of CDRs have been significantly delayed. Many childhood disabilities can improve during the developmental years or with appropriate intervention. There is a higher likelihood to find medical improvement in a childhood claim as opposed to adult CDRs. Many childhood CDRs continue to be sent to the DDSs years past their scheduled diary date. The delays in reviewing a childhood CDR may mean benefits are ceased much later than necessary.

Having well trained, experienced staff with a manageable workload is the best way to prevent incorrect decisions. NADE believes that additional training of new examiners, as well as experienced staff, should be a priority. In recent years, many DDSs elected to reduce the training opportunities available for their limited staff to allow their personnel to devote as much time as possible to the processing of disability claims. With recent approval to hire a large number of employees at the DDSs, some states may provide inadequate training for these new hires to learn the basics of this complicated program. There should be increased efforts to provide training opportunities for all staff as policies change, may be misinterpreted or forgotten. NADE reminds Members of this Committee that the Inspector General has commented on numerous occasions that SSA's best defense against fraud is the well-trained disability examiner. NADE would add the caveat that the well-trained disability examiner must also have a manageable caseload. The Inspector General has previously pointed out that the majority of fraud in the disability program, to date, has been detected by the front line disability examiner in the DDS.

While inadequate staffing levels plague nearly every DDS, some states continue to assign every new claim receipted into the agency to a disability examiner. Other DDSs "stage" new case receipts. The impact of the former practice is that disability examiners are often overwhelmed by the number of claims they have pending at any given time, while the latter practice can result in delays in processing new claims. Work pressures for disability examiners to produce a high number of decisions can create opportunities for mistakes that can be critical in making the correct determination or making judgment that are not fully supported by the evidence. The impact of a high caseload may affect the quality at the initial, reconsideration and CDR level. If an examiner misses details or does not take the time to take additional steps to clarify

an issue, an initial claim may be inappropriately allowed or denied. In the case of an allowance, the claim will likely become a continuance on CDR because MIRS will preclude the DDS from ceasing benefits. CDR workload pressures may affect the thoroughness of review of the CPD evidence. If there is an oversight in the review of CPD evidence, an incorrect determination that a medical condition has not improved may be made. Remember, there is a higher burden of proof for processing CDR claims and the disability examiner must show significant medical improvement has occurred. Because of this, more documentation and rationalization may be needed to prove a cessation is appropriate. When a disability examiner with a high caseload is processing a CDR, the extra effort needed for a cessation may be replaced by the need to spend the available time processing other CDR claims.

Lost Folders

Initial and reconsideration claims completed in the past six to eight years are usually in an electronic format. When the CPD claim file is electronic, the evidence is readily available for review on CDR. Older decisions are likely to be paper cases. If the CPD paper folder is lost, the CDR decision is likely to be a continuance. For a lost folder, the examiner starts by developing the beneficiary's condition to see if they are a current allowance. If the claimant cannot be found disabled currently, then the disability examiner must attempt to recreate the CPD file. This is often a challenging and time-consuming process as it can be difficult to obtain older records. Many medical records are destroyed after seven years. The disability examiner must often rely upon the memory of the beneficiary to provide information about their condition and treatment at the last decision. The beneficiary has no incentive to provide this information. If the CPD claim file cannot be reconstructed, then the DDS must process a continuance decision (POMS DI 28035.001ff). It is rare when a lost folder can be reconstructed fully and the DDS can make a decision that significant medical improvement has occurred. Due to the difficulty and time that it takes to reconstruct a file and the fact that a continuance is usually the result, some examiners will not put forth the effort to attempt the reconstruction, instead utilizing their time to process other claims.

Lost folder decisions are a small percentage of CDRs. However, this still results in great cost to the trust fund. DDS examiners are expected to assign a specific list code for CDR claims that involve a lost CPD claim folder. Unfortunately, not every DDS personnel ensure this list code is properly used. Consequently, there are likely more lost folder continuance decisions than SSA is aware.

The policy regarding exceptions to MIRS does not apply with a lost folder. This becomes difficult in a case where there is clear fraud or similar fault found only at CDR, and not at CPD. If the DDS and CDIU are unable to reconstruct the CPD file, then the claim is treated as a lost folder and benefits would continue, regardless of the current finding of fraud or similar fault. This is very concerning because the current CDR decision will be the CPD for the next CDR, since the CDR evaluates only if medical improvement from the last decision can be established. To cease benefits at a future CDR in these types of claims, medical improvement would need to be established from the current decision where fraud or similar fault was found.

There are multiple reasons for lost folders. For example, there was a flood at one storage facility, which destroyed some folders. Since the majority of claims are now processed electronically, the business process for handling paper folders may be forgotten or overlooked. Because of this, folders may not be appropriately documented when transferred to the appropriate storage facility.

As mentioned above, the transition to electronic files significantly reduced the number of lost folders for subsequent CDRs. Even so, there are still system limitations that require a claim to be processed as a paper file. SSA has been reluctant to scan in paper files due to cost. It may be worth studying the possibility of scanning in prior allowances that are scheduled to be reviewed for CDR prior to retirement. Additionally, there may be benefit to reviewing the business processes for handling paper claims.

Impact of Lack of Current Treatment

When there is a lack of current medical evidence from a qualified treating source in CDR claims, the DDS must purchase a consultative examination (CE). This "one-shot" exam, for better or worse, becomes the primary evidence used by the DDS in making a decision on the CDR. That decision can be based on how well, or how poorly, the claimant was feeling on the day of their CE. This scenario can lead to an incorrect decision. For conditions that rely upon more subjective information, longitudinal evidence increases the likelihood of making the appropriate decision. Many beneficiaries do not have current or ongoing medical treatment for the impairment for which they were allowed. The majority of disability beneficiaries have access to medical care, although many do not take advantage of this access. Some beneficiaries only seek treatment when they receive notice of the CDR. This behavior may lead a disability examiner to question the motivation for seeking medical treatment only when their benefits are up for review. NADE continues to advocate for the removal of the two-year waiting period for Medicare. This would allow all disability beneficiaries to have access to treatment. NADE would also recommend a study regarding the possibility of requiring treatment for certain conditions that may improve.

Summary

The current CDR backlog of 1.3 million is the result of an agency with inadequate staff and resources to address all needs. SSA and DDSs had a high attrition rate and were not able to replace all staff. The decreased workforce combined with an increase in initial claim filings, resulted in the prioritization of initial claims. SSA has announced its intention of addressing the backlog by increasing the number of CDRs sent to the DDSs for processing in the next few years. Additional personnel and funding will be needed from Congress if this effort is to be successful and sustained.

Due to the MIRS policy, few claims are actually ceased at CDR. An examiner is not able to fix a seeming "mistake" in a previous decision with this policy if there is no clear, objective error. Distinctions must be made between objective errors versus subjective conclusions in considering the error exception. They are called "exceptions" for a reason and their utilization

in the DDSs will be infrequent as they are appropriate for a small percentage of claims. Additional training and emphasis on this policy may improve its utilization but the exceptions will not save the trust fund. There will not be a dramatic increase in the rate of cessations through the proper use of the exceptions rule. Perhaps it is time to explore options to MIRS.

New hires in the DDS are welcome but it takes an average of two to four years for a disability examiner to become proficient at their job. It is critical that SSA and the DDSs be allowed to replace personnel lost to attrition. An increase in training opportunities to ensure the success of new personnel, as well as the continued success of current staff, is necessary.

Even though claims are processed electronically now, on CDR there are many claims where the CPD was a paper file. Lost folders continue to be a problem.

CDIUs are an effective tool in the campaign against fraud or similar fault in the disability program. CDIUs have been shown to be very cost effective with savings of $16 for every $1 spent.

Training at all levels of adjudication is important to ensure that the decision maker is current on program policies.

Recommendations

- NADE supports the continued expansion of CDIU.
- Revisions to the fraud or similar fault policy are needed.
- Revision of the MIRS process for CDRs should be considered. NADE would support a de novo review on CDR.
- Additional training and clarification on the exceptions to MIRS policy would be beneficial.
- Quality review at all levels of adjudication is needed.
- Electronic claim exceptions should be eliminated to prevent any future claims being processed in paper format.
- Improved documentation of the location of paper files is needed to prevent additional lost folders.
- The lost folder policy should not apply to cases of fraud or similar fault.
- Eliminating the two-year waiting period for Medicare, to allow increased access to medical coverage.

- There should be consideration of the possibility of requiring treatment for conditions that may improve.

- Continued training opportunities are needed at all levels of adjudication, with an emphasis on policy.

- Appropriate funding for staffing is needed to ensure there are well-trained, experienced examiners with manageable caseloads.

- To ensure policy compliance, the DDS should be represented at the ALJ review.

SSA defines disability as the inability to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to result in death, or has lasted for a continuous period of not less than 12 months. To be found disabled, the individual must prove that they meet the strict definition of disability; however at CDR, the definition is removed. When completing CDR claims, MIRS is used to determine if beneficiaries still meet the requirements for disability. The change in definitions from the initial to CDR level is important because a decision can rarely be "fixed" at the CDR level. However, if a "mistake" does occur and a decision is not clearly an error, MIRS precludes the DDS from correcting the "mistake" at CDR. Consequently, many beneficiaries who no longer meet SSA's definition of disability are continued at the CDR level. Perhaps it is time to reconsider the options.

NADE appreciates this opportunity to present our views on the effectiveness of SSA's current process to medically review beneficiaries to determine if they should continue to receive federal disability benefits.

Jennifer Nottingham Biography

Jennifer Nottingham is the president of the National Association of Disability examiners (NADE). NADE is a professional association whose purpose is to promote the art and science of disability evaluation. The majority of members work in the state Disability Determination Service (DDS) agencies and are on the "front-line" of the disability evaluation process. Jennifer has her Master of Arts in Public Administration from The Ohio State University. She has worked for the past fifteen years at the Ohio DDS. She was a disability claims examiner for eight years and for the past five years has been a disability claims supervisor, managing a staff of eight disability claims examiners. She has been an active member of NADE for twelve years. She previously served as her local chapter secretary and president. She has been on the NADE board for the past four years, having served as a regional director and now as president.

Committee on Oversight and Government Reform
Witness Disclosure Requirement – "Truth in Testimony"
Required by House Rule XI, Clause 2(g)(5)

Name: Jennifer Nottingham

1. Please list any federal grants or contracts (including subgrants or subcontracts) you have received since October 1, 2011. Include the source and amount of each grant or contract.

none

2. Please list any entity you are testifying on behalf of and briefly describe your relationship with these entities.

The National Association of Disability Examiners, President

3. Please list any federal grants or contracts (including subgrants or subcontracts) received since October 1, 2010, by the entity(ies) you listed above. Include the source and amount of each grant or contract.

none

I certify that the above information is true and correct.

Signature: Jennifer Nottingham Date: 4/6/14