MEDICAL SOURCE INSTRUCTION SHEET FOR COMPLETION OF ATTACHED DHCS 7035 C (Medical Report on Child With Allegation of Human Immunodeficiency Virus [HIV] Infection)

A claim has been filed for your patient, identified in Section A of the attached form, for Medi-Cal disability benefits based on HIV infection.
MEDICAL SOURCE: Please detach this instruction sheet and use it to complete the attached form.

I. PURPOSE OF THIS FORM:

If you complete and return the attached form promptly, your patient may be able to receive medical benefits while we are processing his or her claim for ongoing disability benefits.

This is not a request for an examination. At this time, we simply need you to fill out this form based on existing medical information. The State Disability Evaluation Division may contact you later to obtain further evidence needed to process your patient's claim.

II. WHO MAY COMPLETE THIS FORM:

A physician, nurse, or other member of a hospital or clinic staff, who is able to confirm the diagnosis and severity of the HIV disease manifestations based on your records, may complete and sign the form.

III. MEDICAL RELEASE:

A Department of Health Care Services medical release (MC 220) signed by your patient's parent or guardian should be attached to the form when you receive it. If the release is not attached, the medical release section on the form itself should be signed by your patient's parent or guardian.

IV. HOW TO COMPLETE THE FORM:

- If you receive the form from your patient's parent or guardian and Section A has not been completed, please fill in the identifying information about your patient.
- You may not have to complete all of the sections on the form.
- **ALWAYS complete Section B.**
- **Complete Section C, if appropriate**. If you check at least one of the items in Section C, go right to Section E.
- **ONLY complete Section D if you have NOT checked any item in Section C**. See the special information section below which will help you to complete Section D.
- **Complete Section E if you wish to provide comments on your patient's condition(s).**
- **ALWAYS complete Sections F and G. NOTE: This form is not complete until it is signed.**

V. HOW TO RETURN THE FORM TO US:

- Mail the completed, signed form as soon as possible in the return envelope provided.
- If you received the form without a return envelope, give the completed, signed form back to your patient's parent or guardian for return to the county department of social services.

VI. SPECIAL INFORMATION TO HELP YOU TO COMPLETE SECTION D:

How We Use Section D:

- Section D asks you to tell us what other manifestations of HIV your patient may have. It also asks you to give us an idea of how your patient's ability to function has been affected. Complete only the areas of functioning applicable to the child's age group.
- We do not need detailed descriptions of the functional limitations imposed by the illness; we just need to know whether your patient's ability to function has been affected to the extent described.
- For children age 3 to attainment of age 18, the child must have a "marked" restriction of functioning in two areas to be eligible for these benefits. See below for an explanation of the term "marked."

Special Terms Used in Section D:

What We Mean By "Manifestations of HIV Infection" *(see Item D.1)* :

"Manifestations of HIV Infection" may include any conditions listed in Section C, but without the findings specified there, (e.g., oral candidiasis not meeting the criteria shown in Item 27 of the form, diarrhea not meeting the criteria shown in Item 38 of the form); or any other conditions that is not listed in Section C, (e.g., oral hairy leukoplakia, hepatomegaly).

Continued on reverse (

What We Mean By "Marked" ***(see Item D.2.c—Applies Only to Children Age 3 to 18):***

- When "marked" is used to describe functional limitations, it means more than moderate, but less than extreme. "Marked" does not imply that your patient is confined to bed, hospitalized, or placed in a residential treatment facility.
- A marked limitation may be present when several activities or functions are impaired or even when only one is impaired. An individual need not be totally precluded from performing an activity to have a marked limitation, as long as the degree of limitation is such as to seriously interfere with the ability to function independently, appropriately, and effectively in an age-appropriate manner.

PRIVACY ACT NOTICE

The Department of Health Care Services (DHCS) is authorized to collect the information on this form under Sections 205(a), 233(d), and 1633(e)(1) of the Social Security Act. The information on this form is needed by DHCS to make a decision on the named applicant's application for Medi-Cal based on disability. While giving us the information on this form is voluntary, failure to provide all or part of the requested information could prevent an accurate or timely decision on the named applicant's application. Although the information you furnish is almost never used for any purpose other than making a determination about the applicant's disability, such information may be disclosed by DHCS as follows: (1) to enable a third party or agency to assist DHCS in establishing rights to Medi-Cal benefits, and (2) to facilitate statistical research and audit activities necessary to assure the integrity and improvement of the Medi-Cal program.

We may also use the information you give us when we match records by computer. Matching programs compare our records with those of other federal, state, and local government agencies. Many agencies may use matching programs to find or prove that a person qualifies for benefits paid by the Federal Government. The law allows us to do this even if you do not agree to it.

Federal law governing Medicaid requires that medical information on applicants and beneficiaries be kept confidential. [(42 United States Code, Section 139a (a) (7).)] The regulations implementing this law deal with the disclosure of information collected and maintained by state Medicaid agencies. (42 California Federal Register, Sections 431.300 et seq.)

MEDICAL REPORT ON CHILD WITH ALLEGATION OF HUMAN IMMUNODEFICIENCY VIRUS (HIV) INFECTION

The individual named below has filed an application for disability under the Medi-Cal program. If you complete this form, your patient may be able to receive early medical benefits. (This is not a request for an examination, but for existing medical information.)

MEDICAL RELEASE INFORMATION

☐ Form MC 220, "Authorization to Release Medical Information" to the Department of Health Care Services, attached.

☐ I hereby authorize the medical source named below to release or disclose to the Department of Health Care Services or Department of Social Services any medical records or other information regarding the child's treatment for human immunodeficiency virus (HIV) infection.

Applicant's Parent's or Guardian's Signature (Required only if Form MC 220 is NOT attached)	Date

A. IDENTIFYING INFORMATION:

Medical Source's Name	Applicant's Name
Applicant's Social Security Number	**Applicant's Date of Birth**

B. HOW WAS HIV INFECTION DIAGNOSED?

☐ Laboratory testing confirming HIV infection

☐ Other clinical and laboratory findings, medical history, and diagnosis(es) indicated in the medical evidence

C. OPPORTUNISTIC AND INDICATOR DISEASES (Please check, if applicable)**:**

BACTERIAL INFECTIONS:

1. ☐ **Mycobacterial Infection,** (e.g. caused by M. avium-intracellulare, M. kansasii, or M. tuberculosis), at a site other than the lungs, skin, or cervical or hilar lymph nodes
2. ☐ **Pulmonary Tuberculosis,** resistant to treatment
3. ☐ **Nocardiosis**
4. ☐ **Salmonella Bacteremia,** recurrent nontyphoid
5. ☐ **Syphilis or Neurosyphilis,** (e.g., meningovascular syphilis) resulting in neurologic or other sequelae
6. ☐ In a child less than 13 years of age, **Multiple or Recurrent Pyogenic Bacterial Infection(s)** of the following types: sepsis, pneumonia, meningitis, bone or joint infection, or abscess or an internal organ or body cavity (excluding otitis media or superficial skin or mucosal abscesses) occurring two or more times in two years
7. ☐ **Multiple or Recurrent Bacterial Infection(s),** including pelvic inflammatory disease, requiring hospitalization or intravenous antibiotic treatment three or more times in one year

FUNGAL INFECTIONS:

8. ☐ **Aspergillosis**
9. ☐ **Candidiasis,** at a site other than the skin, urinary tract, intestinal tract, or oral or vulvovaginal mucous membranes; or candidiasis involving the esophagus, trachea, bronchi, or lungs

NOTE: If you **have** checked any of the boxes in **Section C**, proceed to **Section E** to add any remarks you wish to make about this patient's condition. Then proceed to **Sections F and G** and sign and date the form.

If you have **not** checked any of the boxes in **Section C**, please complete **Section D**. See Part VI of the Instruction Sheet for definitions of the terms we use in **Section D**. Proceed to **Section E** if you have any remarks you wish to make about this patient's condition. Then, proceed to **Sections F and G** and sign and date the form.

D. OTHER MANIFESTATIONS OF HIV INFECTION:

1. Any Manifestations of HIV Infection Including Any Diseases Listed in Section C, Items 1–47, but without the specified findings described above, or any other manifestations of HIV infection; please specify type of manifestation(s):

_____

_____

_____

AND

2. Any of the Following Functional Limitation(s), Complete Only the Items for the Child's Present Age Group:

a. Birth to Attainment of Age One—Any of the following:

(1) ☐ **Cognitive/Communicative Functioning** generally acquired by children no more than one-half the child's chronological age, (e.g., in infants birth to six months, markedly diminished variation in the production or imitation of sounds and severe feeding abnormality, such as problems with sucking, swallowing, or chewing); or

(2) ☐ **Motor Development** generally acquired by children no more than one-half the child's chronological age; or

(3) ☐ **Apathy, Over-Excitability, or Fearfulness,** demonstrated by an absent or grossly excessive response to visual stimulation, auditory stimulation, or tactile stimulation; or

(4) ☐ **Failure to Sustain Social Interaction** on an ongoing, reciprocal basis as evidenced by inability by six months to participate in vocal, visual, and motoric exchanges (including facial expressions); or failure by age nine months to communicate basic emotional responses, such as cuddling or exhibiting protest or anger; or failure to attend to the caregiver's voice or face or to explore an inanimate object for a period of time appropriate to the infant's age; or

(5) ☐ **Attainment of Development or Function** generally acquired by children no more than two-thirds of the child's chronological age in two or more areas (i.e., cognitive/communicative, motor, and social).

b. Age One to Attainment of Age Three—Any of the following:

(1) ☐ **Gross or Fine Motor Development** at a level generally acquired by children no more than one-half the child's chronological age; or

(2) ☐ **Cognitive/Communicative Function** at a level generally acquired by children no more than one-half the child's chronological age; or

(3) ☐ **Social Function** at a level generally acquired by children no more than one-half the child's chronological age; or

(4) ☐ **Attainment of Development or Function** generally acquired by children no more than two-thirds of the child's chronological age in two or more areas covered by 1, 2, or 3.

c. Age 3 to Attainment of Age 18—Limitation in at least two of the following areas:

(1) ☐ Marked impairment in age-appropriate **Cognitive/Communicative Function** (considering historical and other information from parents or other individuals who have knowledge of the child, when such information is needed and available); or

(2) ☐ Marked impairment in age-appropriate **Social Functioning** (considering information from parents or other individuals who have knowledge of the child, when such information is needed and available); or

(3) ☐ Marked impairment in **Personal/Behavioral Function** as evidenced by marked restriction of age-appropriate activities of daily living (considering information from parents or other individuals who have knowledge of the child, when such information is needed and available); or persistent serious maladaptive behaviors destructive to self, others, animals, or property, requiring protective intervention; or

(4) ☐ **Deficiencies of Concentration, Persistence, or Pace** resulting in frequent failure to complete tasks in a timely manner.

E. REMARKS (Please use this space if you lack sufficient room in Section D or to provide any other comments you wish about your patient.)**:**

F. MEDICAL SOURCE INFORMATION (Please Print or Type)**:**

Name

Street Address	City	State	ZIP Code

Telephone Number (Include Area Code)	Date
( )	

I declare under penalty of perjury under the laws of the United States of America and the State of California that the information contained in this medical report is true and correct.

G. SIGNATURE AND TITLE OF PERSON COMPLETING THIS FORM (e.g., physician, R.N.):

FOR OFFICIAL USE ONLY

❒ COUNTY OFFICE DISPOSITION:

❒ DISABILITY EVALUATION DIVISION DISPOSITION: