STATE OF CALIFORNIA—HEALTH AND WELFARE AGENCY PETE WILSON, Governor

DEPARTMENT OF HEALTH SERVICES
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P.O. BOX 942732
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December 11, 1992

MEDI-CAL ELIGIBILITY MANUAL LETTER NO. 105

TO: Holders of the Medi-Cal Eligibility Manual
All County Welfare Directors
All County Administrative Officers
All County Medi-Cal Program Specialists/Liaisons

SUBJECT: COUNTY PROCEDURES FOR DETERMINING PRESUMPTIVE DISABILITY

ALL COUNTY WELFARE DIRECTORS LETTER (ACWDL) NO. 92-33

Enclosed are procedural revisions to Article 4C of the Medi-Cal Eligibility Manual.

The purpose of this manual update is to transmit to counties, procedures to follow when making a Presumptive Disability (PD) determination for an individual who alleges disability based on the Human Immunodeficiency Virus (HIV) infection. The reason these procedures are being updated is the Social Security Administration (SSA) revised and expanded their procedures for making PD decisions based on the HIV infection. No other part of the county procedures for PD has been changed with the exception of requiring that counties: 1) explain to the applicant/beneficiary that PD only allows the county to temporarily grant Medi-Cal eligibility pending the disability determination made by the Department of Social Services, Disability Evaluation Division (DED); 2) indicate on the Notice of Action that the approval or denial was based on PD; and 3) indicate on the DED packet if PD was approved (this will alert DED to place a high priority on the case). These procedures will replace existing Article 4C of the Medi-Cal Eligibility Manual (MEM).

PLEASE NOTE: The new HIV PD procedures under number 13. are based on proposed SSA regulations which have not yet been adopted. However, we will be implementing these proposed regulations in the interim. Implementation of the revised procedures should take place no later than April 1, 1993. We will revise our regulations in Title 22, California Code of Regulations, Section 50167 (a)(C)13. upon adoption of SSAs final regulations.

Background

The SSA revised and expanded their procedures for making decisions based on HIV infection. PD is determined by their Field Office staff for purposes of determining eligibility for Supplemental Security Income and disability under Title II of the Social Security Act. These revised procedures permit SSA to identify individuals who meet the requirements for PD because of HIV infection at the earliest possible stage in the application

Previously, PD was authorized only for individuals with a full blown AIDS diagnosis. Under the revised criteria, adults and children can meet PD requirements when there is evidence of an HIV infection and the individual's medical source confirms that the disease manifestations are of listing-level severity. Listing-level severity means that an applicant's symptoms meet specified criteria to establish disability based on the HIV infection. SSA developed two separate forms to determine listing-level severity: one for adults and one for children which addresses specific criteria that apply only to children. The current DHS 7035 (Medical Verification - AIDS) form has been revised to reflect the new criteria. There are now two forms: one for adults and one for children.

Currently, when an applicant/beneficiary alleges AIDS the eligibility worker (EW) would complete the DHS 7035 form. Implementation of SSA's new procedures will revise and expand the EW's role in processing PDs in HIV infection cases. County EW staff will need to evaluate a more extensive HIV/AIDS form(s).

The revised procedures include copies of the "PHYSICIAN'S REPORT ON ADULT WITH ALLEGATION OF HUMAN IMMUNODEFICIENCY VIRUS (HIV) INFECTION" (DHS 7035 A) and the "PHYSICIAN'S REPORT ON CHILD WITH ALLEGATION OF HUMAN IMMUNODEFICIENCY VIRUS (HIV) INFECTION" (DHS 7035 C) (see exhibits 1 and 2). To minimize the impact of the new procedures on the EW they have been written in a manner that will require NO judgment of medical evidence on the part of the EW. Depending upon which combination of boxes the doctor completes on either the DHS 7035 A or the DHS 7035 C, the EW by reviewing exhibits 4, 5, or 6 (Adult or Child Claims) of these procedures can determine if PD exists.

The following description identifies the reason for the revisions to the procedure manual:

Procedure Revision	Description
Article 4C	Procedures for Determining Presumtive Disability - revised to include Human Immunodeficiency Virus Infection

Filing Instructions

Remove Pages	Insert Pages
4C-1 through 4C-4	4C-1 through 4C-5 Insert exhibits 1 through 7 after page 4C-5

If you have any questions on this issue, please contact RaNae Dunne of my staff at (916) 657-0714.

Sincerely,

Original signed by
Glenda Arellano

for Frank S. Martucci, Chief
Medi-Cal Eligibility Branch

Enclosures

4C - COUNTY PROCEDURES FOR DETERMINING PRESUMPTIVE DISABILITY

I. BACKGROUND

In most cases, an applicant/beneficiary must be determined disabled through a federal or state evaluation process prior to approval of Medi-Cal based on disability. However, applicants/beneficiaries with certain conditions are presumed to be disabled, and eligibility may be granted while the Disability Evaluation Division (DED) referral is being determined. Section 50167 (a)(1)(D) requires the county to submit the request for disability evaluation to DED within ten days of the date the Statement of Facts, (MC 210) is received. The disability determination referral process is described in Procedure Manual Section 4A II. ONLY APPLICANTS/BENEFICIARIES WHO HAVE CONDITIONS THAT ARE LISTED CAN BE GRANTED Presumptive Disability (PD).

II. PURPOSE

These procedures instruct counties how to determine if an applicant/beneficiary meets certain conditions in order to be granted PD.

III. IMPLEMENTATION

County welfare departments shall implement these procedures no later than April 1, 1993.

IV. WHEN TO USE THIS PROCEDURE:

Counties should use these procedures when the applicant/beneficiary provides the county with a medical statement from his/her physician verifying the condition(s) specified below and the applicant/beneficiary is otherwise eligible.

V. PROCEDURE:

Counties should explain to the applicant/beneficiary that PD only allows the county to temporarily grant Medi-Cal eligibility pending the disability determination made by DED. Counties should also indicate on the Notice of Action whether the approval or denial was based on PD and indicate in the DED packet (under the "CWD Representative Comments" column on the MC 221) if PD was approved.

Initiate PD when the applicant/beneficiary meets any of the following conditions:

A. Cancer which is expected to be terminal despite treatment. This category does not include persons whose condition is terminal unless treated.

B. Paraplegia or quadriplegia. Paraplegia means permanent paralysis of both legs. Quadriplegia means permanent paralysis of all four limbs. This category does not include temporary paralysis of two or more limbs or hemiplegia (paralysis of one side of the body, including one arm and one leg). NOTE: Refer to number 8. regarding hemiplegia due to a stroke.

C. Severe retardation with an IQ of less than 50. This category does not include persons who are comatose or unconscious unless the person's conscious functional IQ would be less than 50.

D. Absence of more than one limb. This category includes persons absent two arms, two legs, or one arm and one leg.

E. Amputation of a leg at the hip. Individuals with a leg amputated at the hip are unable to wear a prosthesis, and thus, will be required to use two crutches or a wheelchair.

F. Total deafness. Total deafness is defined as the complete lack of any ability to hear in both ears regardless of decibel level and despite amplification (hearing aid). Persons wearing hearing aids are not totally deaf as some ability to hear is present.

G. Total blindness. Total blindness means complete lack of vision and not legal blindness. Persons wearing glasses are not considered totally blind as some vision is present. The term "glasses" does not include the nonprescription sunglasses worn by some blind individuals.

H. Hemiplegia due to a stroke providing the stroke occurred more than three months in the past. Hemiplegia is paralysis of one side of the body, including one arm and one leg. This condition is often present immediately following a stroke but may improve in the next few months. As a result, a three-month delay in evaluating the applicant's/beneficiary's condition is required by federal law. DED cannot develop the disability case until that three-month delay is completed. However, the EW should forward the disability packet to DED as usual. DO NOT HOLD THE PACKET FOR THE THREE MONTH PERIOD. When application is made in the same month as the stroke occurred, DED must delay case development. However, while PD is also delayed until the expiration of the three-month period, once that period has expired, the EW should (providing hemiplegia still exists) grant PD back to the date of application. The applicant/beneficiary will thus be eligible until DED completes the evaluation.

NOTE: The three-month period begins the date of the stroke, not the application date

I. Cerebral palsy, muscular dystrophy, or muscle atrophy with marked difficulty in walking requiring the use of two crutches, a walker, or a wheelchair. The physician's statement must clearly state one of these three diagnoses. Other individuals on crutches, walkers, or using a wheelchair are not presumed disabled unless they meet the criteria for one of the other impairments indicated.

J. Diabetes with the amputation of one foot. This combination of impairments is considered disabling because the amputation is usually due to circulatory failure caused by the diabetes. Diabetes which has progressed to that point will meet the disability criteria.

K. Down's syndrome with an IQ of 59 or less. In order to be determined PD, the physician's statement must clearly indicate a diagnosis of Down's syndrome. Retardation due to any other condition must meet the criteria shown in number C. above. The higher permissible IQ level for Down's syndrome patients is due to the other disabling aspects of that syndrome.

L. End stage renal disease requiring chronic dialysis or kidney transplant. This category does not include acute renal failure requiring temporary dialysis until kidney function resumes.

M. A diagnosis of Acquired Immunodeficiency Syndrome (AIDS)/Human Immunodeficiency Virus (HIV) infection confirmed by reliable and currently accepted tests with one of the secondary conditions recognized by the Social Security Administration as establishing presumptive disability due to AIDS/HIV. AIDS is characterized by the inability of the body's natural immunity to fight infection. It is caused by a retrovirus known as human immunodeficiency virus, or HIV, and is characterized by susceptibility to one or more opportunistic diseases, cancers, or other conditions. Generally speaking, people with HIV infection fall into two broad categories:

- o those with symptomatic HIV infection, including AIDS; and
- o those with HIV infection but no symptoms.

PLEASE NOTE: All reference to AIDS hereupon will be referred to as HIV.

The diagnosis of HIV must meet certain conditions listed on either the DHS 7035A (adults) or the DHS 7035C (children) (Medical Verification - HIV) (see exhibits 1 and 2). An individual is considered an adult for the purposes of determining PD the day of their 18th birthday.

Where a diagnosis of HIV infection is suspected but is not confirmed by laboratory tests or clinical findings, disability CANNOT be presumed. In addition, if a diagnosis of HIV infection is made but none of the conditions shown on the HIV form(s) exist, the county CANNOT find the person to be PD. However, the case should continue to be processed under regular disability evaluation procedures. Counties should specify to EXPEDITE the case under the "CWD Representative Comments" column on the MC 221.

In order to minimize the amount of follow-up activity by EWs and ensure all necessary information is obtained, forms DHS 7035A and DHS 7035C, must be completed by the treating physician. A blank DHS 7035A or DHS 7035C should be provided to either the applicant/beneficiary or physician with a cover letter and return envelope (see exhibit 3). Counties may want to appoint a district coordinator to receive the returned HIV form(s), to preserve confidentiality of information.

THE FOLLOWING PROVIDES COUNTIES WITH SPECIFIC PROCEDURES:

A. POLICY

a. The county may make a finding of PD for individuals

- o Who allege HIV infection

  AND

- o Whose disease manifestations are of listing-level severity as outlined in exhibits 4, 5 and 6.

  AND

- o The presence of the disease manifestations is confirmed by the treating source.

b. Forms used to verify the presence of the disease manifestations are:

- o Form DHS 7035A "Physician's Report on Adult With Allegation of HIV Infection," (see exhibit 1).
- o Form DHS 7035C "Physician's Report on Child With Allegation of HIV Infection," (see exhibit 2).

B. PROCEDURE - APPLICANT ALLEGES HIV INFECTION:

When processing claims for individuals alleging HIV infection, the county should take the following actions:

1. Authorization For Release of Medical Information

a. Complete the MC 220A "Authorization For Release of Medical Information - HIV", including the applicant's signature (see exhibit 7).

b. Attach the signed MC 220A to the DHS 7035A or DHS 7035C.

NOTE: Although the DHS 7035A and DHS 7035C contains an abbreviated medical release, the county should also use the MC 220A. The abbreviated medical release is provided in the event that the form is completed without access to an MC 220A.

2. DHS 7035A - DHS 7035C

Complete the DHS 7035A/DHS 7035C, as appropriate.

a. Check the "Medical Release Information" space on the check-block form "DHS 7035A/DHS 7035C.

b. Enter the applicant's medical source's name in the space marked "Physician's Name".

c. Enter the applicant's name, social security number, and date of birth in the appropriate space.

3. Cover Letter

Use the model cover letter, (see exhibit 3), to request the medical source to complete the DHS 7035A/DHS 7035C.

4. Return Envelope

Prepare a return envelope which identifies the appropriate County contact person and address.

5. Mailing of the DHS 7035A or DHS 7035C

Give the following information to either the applicant/beneficiary or mail the information to the medical source:

- o the cover letter;
- o return envelope;
- o DHS 7035A or DHS 7035C, as applicable; and
- o MC 220A

The appropriate information must be completed by the medical source and returned to the county.

6. County Actions Prior to Return of the Form

The county will not hold the disability packet pending receipt of the form(s), but will flag the packet and forward it to the DED using existing procedures outlined in 4A II. The county should indicate on the DED packet (under the "CWD Representative Comments" column on the MC 221A) that PD is pending.

7. Form Returned to County

Upon return of the DHS 7035A or DHS 7035C, as applicable, the county will review the form, verify that the physician has signed the form, and make a finding of PD if any combination of blocks has been checked as specified in exhibits 4, 5 and 6.

a. The county will make a finding of PD, if appropriate, even if the file has already been forwarded to DED.

b. Prior to forwarding the form to DED, counties should contact DED to determine the location of the packet (what analyst has been assigned to the case) and forward the form appropriately. A cover sheet should be attached to the form indicating the: 1) case name; 2) Social Security Number; 3) date the original packet was sent to DED; and 4) status of the pending PD case.

8. Medical Evidence of Record Received in the County	If medical evidence of record is received in the county, along with the completed DHS 7035A or DHS 7035C form, make the PD finding, if applicable, and forward the evidence to DED. Counties should indicate the status of the PD determination either on the MC 221A or on the cover sheet. If medical evidence is received after the DHS 7035A or DHS 7035C has been received, forward this information to DED.
9. County is Able to Make PD Decision	After the PD finding has been made following the procedures outlined in exhibits 4, 5 and 6, the county will complete the packet and forward to the DED.
10. County Unable to Make a Finding of PD	If the county is unable to make a finding PD because the form has not been appropriately completed, or if the county is unable to make a PD for any other reason, forward the form to DED. This will allow the DED analyst to develop the case further.

STATE OF CALIFORNIA -
HEALTH AND WELFARE AGENCY

EXHIBIT 1

MEDICAL VERIFICATION - HIV

PHYSICIAN'S REPORT ON ADULT WITH ALLEGATION OF HUMAN IMMUNODEFICIENCY VIRUS (HIV) INFECTION

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

MEDI-CAL RELEASE INFORMATION

☐ Form MC 220A "Authorization For Release of Medical-AIDS information" attached.

☐ I hereby authorize the medical source named below to release or disclose to the Department of Health Services or Department of Social Services any medical records or other information regarding my treatment for Human Immunodeficiency Virus (HIV) Infection.

APPLICANT'S SIGNATURE ➤ Sign Here	Date

PHYSICIAN'S NAME	APPLICANT'S NAME
A. PLEASE CHECK APPROPRIATE BLOCK ☐ HIV Test(s) Performed ☐ HIV Test(s) Not Performed	APPLICANT'S SSN APPLICANT'S DATE OF BIRTH
B. PLEASE INDICATE RESULTS OF HIV TEST(S) ☐ POSITIVE ☐ NEGATIVE	C. PLEASE INDICATE HERE: CD4 (T4) LYMPHOCYTE COUNT: _____ or percent _____ if count not available

D. OPPORTUNISTIC AND INDICATOR DISEASES: ***Please Check, If Present***

1. ☐ HIV encephalopathy
2. ☐ HIV wasting syndrome
3. ☐ Carcinoma of the cervix FIGO stage II and beyond
4. ☐ Anal squamous cell carcinoma
5. ☐ Cardiomyopathy
6. ☐ Nephropathy
7. ☐ Lymphoma of the brain
8. ☐ Hodgkin's disease
9. ☐ Non-Hodgkin's lymphoma (including Burkitt's lymphoma)
10. ☐ M. kansasii disease, disseminated other than or in addition to the lungs, skin, or cervical or hilar lymph nodes
11. ☐ Mycobacterium avium complex
12. ☐ Mycobacterial infection, disseminated beyond the lungs, or lymph nodes

PROTOZOAN OR HELMINTHIC INFECTIONS

13. ☐ Cryptosporidiosis, intestinal with diarrhea for 1 month or more
14. ☐ Isosporiasis, with diarrhea over 1 month
15. ☐ Pneumocystis carinii pneumonia
16. ☐ Strongyloidiasis, extra-intestinal
17. ☐ Toxoplasmosis of the brain
18. ☐ Toxoplasmosis of an organ other than the liver, spleen, or lymph nodes

FUNGAL INFECTIONS

19. ☐ Candidiasis, of the esophagus, trachea, bronchi, or lungs
20. ☐ Candidiasis, disseminated beyond the skin, urinary or intestinal tract, or oral or vulvovaginal mucous membranes
21. ☐ Coccidioidomycosis, disseminated beyond the lungs, or lymph nodes
22. ☐ Cryptococcosis, disseminated beyond the lungs, or involving the central nervous system
23. ☐ Histoplasmosis, disseminated beyond the lungs or lymph nodes

VIRAL INFECTIONS

24. ☐ Cytomegalovirus, of an organ other than the liver, spleen, or lymph nodes
25. ☐ Herpes simplex virus, causing bronchitis
26. ☐ Herpes simplex virus, causing chronic continuous mucocutaneous infection, or infection of the pulmonary or gastrointestinal tract or encephalitis
27. ☐ Herpes simplex virus causing esophagitis
28. ☐ Herpes simplex virus, causing a mucocutaneous ulcer persistent over 1 month
29. ☐ Herpes simplex virus, causing pneumonitis
30. ☐ Progressive multifocal leukoencephalopathy

BACTERIAL INFECTIONS

31. ☐ Salmonella bacteremia, non-typhoid, recurrent
32. ☐ Nocardiosis

NOTE: IF YOU HAVE CHECKED ANY ITEM IN BLOCK D, SKIP BLOCKS E, F, & G, GO TO BLOCKS I & J.

E. OTHER MANIFESTATIONS OF HIV INFECTION PERSISTING OVER A 2 MONTH PERIOD, AND/OR RESISTANT TO THERAPY. *(If one or more of the following is checked, block G must also be completed.)*

33. ☐ Bacterial sepsis
34. ☐ Fungal sepsis
35. ☐ Endocarditis
36. ☐ Kaposi's sarcoma
37. ☐ Meningitis
38. ☐ Peripheral neuropathy
39. ☐ Pneumonia
40. ☐ Pulmonary tuberculosis
41. ☐ Septic arthritis

NOTE: IF YOU HAVE CHECKED ANY ITEM IN BLOCK E, YOU NEED NOT COMPLETE BLOCK F, GO TO BLOCK G.

F. OTHER MANIFESTATIONS OF HIV INFECTION PERSISTING OVER A 2 MONTH PERIOD, AND/OR RESISTANT TO THERAPY. (If two or more of the following are checked, block G. must also be completed.)

42. ☐ Anemia-Hct. less than or equal to 30%
43. ☐ Granulocytopenia (absolute neutrophil count less than or equal to 1000/mm³)
44. ☐ Thrombocytopenia (less than or equal to 40,000/mm³)
45. ☐ Dermatological conditions, persistent
46. ☐ Diarrhea, persistent and unresponsive
47. ☐ Documented temperature of 100.4° F. (38°C) or greater
48. ☐ Herpes zoster, chronic
49. ☐ Herpes zoster, recurrent
50. ☐ Oral hairy leukoplakia
51. ☐ Mucosal candidiasis (including vulvovaginal)
52. ☐ Sinusitis, persistent or recurrent
53. ☐ Weight loss of greater than or equal to 10% of baseline

G. FUNCTIONAL LIMITATIONS: *(If any of the items in block E. or F. are checked, each of the following items must also be completed.)*

54. Restriction of activities of daily living including, but not limit to, such activities as doing household chores, grooming and hygiene, using a post office, taking public transportation, and paying bills.

☐ Extreme ☐ Marked ☐ Moderate ☐ Mild ☐ None

55. Difficulties in maintaining social function, i.e., capacity to interact appropriately and communicate effectively with others. These restrictions could result from HIV- or treatment-induced fatigue or other symptoms or could result from a pattern of exacerbation and remission caused by the illness itself or its treatment.

☐ Extreme ☐ Marked ☐ Moderate ☐ Mild ☐ None

56. Difficulties in completing tasks in a timely manner due to deficiencies in concentration, persistence, or pace, i.e., the ability to sustain focused attention sufficiently long to permit the timely completion of tasks commonly found in work settings. This could result from symptoms such as extended or intermittent depression, fatigue, or physical functioning or both.

☐ Extreme ☐ Marked ☐ Moderate ☐ Mild ☐ None

57. Repeated episodes of deterioration or decompensation (averaging three times a year or once every four months, lasting two or more weeks each) in work or work-like settings. This may be caused by manifestation of HIV infection itself, such as its symptoms, or by the frequency and intrusiveness of treatment for the disease

☐ Extreme ☐ Marked ☐ Moderate ☐ Mild ☐ None

H. DISCUSSION: *(Please use this space to indicate any other medical conditions of your patient, or to provide any other comments you wish about your patient.)*

I. REPORTING PHYSICIAN'S NAME AND ADDRESS	TELEPHONE NUMBER *(area code)*
	DATE

I certify under penalty of perjury that the above information is true and correct to the best of my knowledge.

J. PHYSICIAN'S SIGNATURE

➤ **Sign Here**

This information is confidential and will not be released without the written consent of the patient.

STATE OF CALIFORNIA -
HEALTH AND WELFARE AGENCY

EXHIBIT 2

MEDICAL VERIFICATION - HIV

PHYSICIAN'S REPORT ON CHILD WITH ALLEGATION OF HUMAN IMMUNODEFICIENCY VIRUS (HIV) INFECTION

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

MEDI-CAL RELEASE INFORMATION

☐ Form MC 220A "Authorization For Release of Medical Information" attached.

☐ I hereby authorize the medical source named below to release or disclose to the Department of Health Services or Department of Social Services any medical records or other information regarding my treatment for Human Immunodeficiency Virus (HIV) Infection.

APPLICANT'S PARENT OR GUARDIAN SIGNATURE ➤ Sign Here	Date

PHYSICIAN'S NAME	APPLICANT'S NAME
A. PLEASE CHECK APPROPRIATE BLOCK ☐ HIV Test(s) Performed ☐ HIV Test(s) Not Performed	APPLICANT'S SSN APPLICANT'S DATE OF BIRTH
B. PLEASE INDICATE RESULTS OF HIV TEST(S) ☐ POSITIVE ☐ NEGATIVE	C. PLEASE INDICATE HERE: CD4 (T4) LYMPHOCYTE COUNT: _____ or percent _____ if count not available

D. OPPORTUNISTIC AND INDICATOR DISEASES: *Please Check, If Present*

1. ☐ HIV encephalopathy
2. ☐ HIV wasting syndrome
3. ☐ Carcinoma of the cervix FIGO stage II and beyond
4. ☐ Anal squamous cell carcinoma
5. ☐ Cardiomyopathy
6. ☐ Nephropathy
7. ☐ Failure to thrive, or a falling off from the age-appropriate range of the projected growth curve
8. ☐ Lymphoma of the brain
9. ☐ Lymphoid interstitial pneumonia in a child less than age 13
10. ☐ Pulmonary lymphoid hyperplasia in a child less than age 13
11. ☐ Hodgkin's disease
12. ☐ Non-Hodgkin's lymphoma (including Burkitt's lymphoma)
13. ☐ M. kansasii disease, disseminated other than or in addition to the lungs, skin, or cervical or hilar lymph nodes
14. ☐ Mycobacterium avium complex
15. ☐ Mycobacterial infection, disseminated beyond the lungs, or lymph nodes
16. ☐ Progressive neurological disease

PROTOZOAN OR HELMINTHIC INFECTIONS

17. ☐ Cryptosporidiosis, intestinal with diarrhea more than 1 month
18. ☐ Isosporiasis, with diarrhea more than 1 month
19. ☐ Pneumocystis carinii pneumonia
20. ☐ Strongyloidiasis, extra-intestinal
21. ☐ Toxoplasmosis of the brain
22. ☐ Toxoplasmosis of an organ other than the liver, spleen, or lymph nodes

FUNGAL INFECTIONS

23. ☐ Candidiasis, of the esophagus, trachea, bronchi, or lungs
24. ☐ Candidiasis, disseminated beyond the skin, urinary or intestinal tract, or oral or vulvovaginal mucous membranes
25. ☐ Coccidioidomycosis, disseminated beyond the lungs, or lymph nodes
26. ☐ Cryptococcosis, disseminated beyond the lungs, or involving the central nervous system
27. ☐ Histoplasmosis, disseminated beyond the lungs or lymph nodes

VIRAL INFECTIONS

28. ☐ Cytomegalovirus, of an organ other than the liver, spleen, or lymph nodes
29. ☐ Herpes simplex virus, causing bronchitis
30. ☐ Herpes simplex virus, causing chronic continuous mucocutaneous infection, or infection of the pulmonary or gastrointestinal tract or encephalitis
31. ☐ Herpes simplex virus causing esophagitis
32. ☐ Herpes simplex virus, causing a mucocutaneous ulcer persistent over 1 month
33. ☐ Herpes simplex virus, causing pneumonitis
34. ☐ Progressive multifocal leukoencephalopathy

BACTERIAL INFECTIONS

35. ☐ Salmonella bacteremia, non-typhoid, recurrent
36. ☐ Nocardiosis
37. ☐ Multiple or recurrent bacterial infections affecting a child less than age 13 (septicemia, pneumonia, meningitis, bone or joint infection, or abscess of an internal organ)

NOTE: IF YOU HAVE CHECKED ANY ITEM IN BLOCK D, SKIP BLOCKS E, F, & G, GO TO BLOCKS I & J.

E. OTHER MANIFESTATIONS OF HIV INFECTION PERSISTING OVER A 2 MONTH PERIOD AND/OR RESISTANT TO THERAPY. *(If one or more of the following is checked, block G. must also be completed.)*

38. ☐ Bacterial sepsis
39. ☐ Fungal sepsis
40. ☐ Endocarditis
41. ☐ Kaposi's sarcoma
42. ☐ Meningitis
43. ☐ Peripheral neuropathy
44. ☐ Pneumonia
45. ☐ Pulmonary tuberculosis
46. ☐ Septic arthritis

NOTE: IF YOU HAVE CHECKED ANY ITEM IN BLOCK E., YOU NEED NOT COMPLETE BLOCK F., GO TO BLOCK G.

F. OTHER MANIFESTATIONS OF HIV INFECTION PERSISTING OVER A 2 MONTH PERIOD AND/OR RESISTANT TO THERAPY. (If two or more of the following are checked, block G. must also be completed.)

47. ☐ Anemia-Hct. less than or equal to 30%
48. ☐ Granulocytopenia (absolute neutrophil count less than or equal to 1000/mm³)
49. ☐ Thrombocytopenia (less than or equal to 40,000/mm³)
50. ☐ Dermatological conditions, persistent
51. ☐ Diarrhea, persistent and unresponsive
52. ☐ Documented temperature of 100.4° F. (38°C) or greater
53. ☐ Herpes zoster, chronic
54. ☐ Herpes zoster, recurrent
55. ☐ Hepatomegaly
56. ☐ Lymphadenopathy, generalized
57. ☐ Mucosal candidiasis (including vulvovaginal)
58. ☐ Oral hairy leukoplakia
59. ☐ Parotitis
60. ☐ Sinusitis, persistent or recurrent
61. ☐ Splenomegaly
62. ☐ Weight loss of greater than or equal to 10% of baseline

G. FUNCTIONAL LIMITATIONS – IF AN ENTRY WAS MADE IN BLOCK E. OR F., AS MANY OF THE FOLLOWING ITEMS AS ARE APPLICABLE MUST ALSO BE COMPLETED. YOU NEED ONLY COMPLETE THE GROUPING PERTAINING TO THE AGE OF YOUR PATIENT.

BIRTH TO ATTAINMENT OF AGE 1 – DEVELOPMENTAL AND EMOTIONAL DISORDERS OF NEWBORN AND YOUNGER INFANTS, EVIDENCED BY A DEFICIT OR LAG IN THE AREAS OF:

63. ☐ Cognitive/communicative functioning generally acquired by children no more than one-half of the child's chronological age. (e.g., in infants 0-6 months, markedly diminished variation in the production or imitation of sounds and severe feeding abnormality, such as problems with sucking swallowing, or chewing); or
64. ☐ Motor development generally acquired by children no more than one-half the child's chronological age; or
65. ☐ Apathy, over-excitability, or fearfulness, demonstrated by an absent or grossly excessive response to *one* of the following:
    - ☐ Visual stimulation, or
    - ☐ Auditory simulation, or
    - ☐ Tactile stimulation; or
66. ☐ Failure to sustain social interaction on an ongoing, reciprocal basis as evidenced by:
    - ☐ Inability by 6 months to participate in vocal, visual, and motoric exchanges (including facial expression), or
    - ☐ Failure by 9 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
67. ☐ 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).
68. ☐ Other:

G. FUNCTIONAL LIMITATIONS (CONT'D) – IF AN ENTRY WAS MADE IN BLOCK E. OR F., AS MANY OF THE FOLLOWING ITEMS AS ARE APPLICABLE MUST ALSO BE COMPLETED.

AGE 1 TO ATTAINMENT OF AGE 3 – FOR OLDER INFANTS AND TODDLERS, PLEASE INDICATE THE FOLLOWING:

69. ☐ Gross or fine motor development at a level generally acquired by children no more than one-half the child's chronological age; or
70. ☐ Cognitive/communicative function at a level generally acquired by children no more than one-half the child's chronological age; or
71. ☐ Social function at a level generally acquired by children no more than one-half the child's chronological age; or
72. ☐ 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 69, 70, or 71.
73. ☐ Other:

AGE 3 TO ATTAINMENT OF AGE 18 – FOR OTHER CHILDREN, PLEASE INDICATE THE FOLLOWING:

NOTE: MARKED MEANS MORE THAN MODERATE, BUT LESS THAN EXTREME.

74. ☐ Marked impairment in age-appropriate cognitive/communicative function (including consideration of historical and other information from parents or other individuals who have knowledge of the child, when such information is needed and available); or
75. ☐ Marked impairment in age-appropriate social functioning (include consideration of historical and other information from parents or other individuals who have knowledge of the child, when such information is needed and available); or
76. ☐ Marked impairment in personal/behavioral function as evidenced by:
    - ☐ Marked restriction of age-appropriate activities of daily living, (including consideration of information from parents or other individuals who have knowledge of the child), or
    - ☐ Persistent serious maladaptive behaviors destructive to self, others, animals, or property, requiring protective intervention; or
77. ☐ Deficiencies of concentration, persistence, or pace resulting in frequent failure to complete tasks in a timely manner.
78. ☐ Other:

H. DISCUSSION: *(Please use this space to indicate any other medical conditions of your patient, or to provide any other comments you wish about your patient.)*

I. REPORTING PHYSICIAN'S NAME AND ADDRESS	TELEPHONE NUMBER *(area code)*
	DATE

I certify under penalty of perjury that the above information is true and correct to the best of my knowledge.

J. PHYSICIAN'S SIGNATURE

➤ Sign Here

This information is confidential and will not be released without the written consent of the patient.

EXHIBIT 3

MODEL COVER LETTER

DEPARTMENT OF HEALTH SERVICES
Medi-Cal Eligibility
(District Office Address)

Refer to:

Date:

(Name and address of treating source):

Dear (Dr.),

RE: (Enter applicant's\beneficiary's name, SSN, and address):

Mr. Ms. Miss applicant's\beneficiary's name has filed a claim for disability benefits under the Medi-Cal Program alleging Acquired Immunodeficiency Syndrome or Human Immunodeficiency Virus Infection.

The State of California's objective is to provide any benefits to which an individual may be entitled as quickly as possible (before making a formal disability decision). To assist us in that endeavor, we are asking that you provide some basic information regarding the condition of the individual stated above. We have enclosed a form for that purpose. A copy of the individual's consent for release of this information is also enclosed.

Please complete the enclosed form and return it in the envelope provided within five (5) days.

To fully evaluate this claim, we also will need copies of medical records you may have. The State Disability Determination Services will recontact you to obtain these records..tb.50" 3.00"

Your prompt response will help ensure a speedy decision on this claim. Thank you for your cooperation.

Sincerely,

(Signature)

Enclosures

Physician's Report on Adult with Human Immunodeficiency Virus (HIV) Infection

(or)

Physician's Report on Child with Human Immunodeficiency Virus (HIV) Infection

Authorization for Release of Medical Information - AIDS (MC 220 A) to the State Department of Health Services

EXHIBIT 4

ADULT CLAIMS

The County Will Make a PD If:	The Following Combination of Blocks Have Been Checked, and Blocks Have Been Completed as Indicated Below:	
	Block A	HIV Test Performed
	Block B	Positive
	Block D	One or more items checked
	Blocks I and J	Physician's name, address, and signature.
	Block A	HIV Test Performed
	Block B	Positive
	Block C	CD4 (T4) count of 200 or less or 14% or less
	Block G	Either "Extreme" or "Marked" has been checked in two of the four items
	Blocks I and J	Physician's name, address, and signature.
	Block A	HIV Test Performed
	Block B	Positive
	Block E	One or more items checked
	Block G	Either "Extreme" or "Marked" has been checked in two of the four items
	Blocks I and J	Physician's name, address, and signature.
	Block A	HIV Test Performed
	Block B	Positive

Block F	Two or more items checked
Block G	Either "Extreme" or "Marked" has been checked in two of the four items
Blocks I and J	Physician's name, address, and signature.

Block A	HIV Test Not Performed
OR	
Block B	Negative
Block D	One or more of the following items have been checked: #7, #10, #11, #13, #15, #17, #19, #22, #24, #25, #27, #28 #29, #30
Blocks I and J	Physician's name, address, and signature.

EXHIBIT 5

CHILD CLAIMS -

CHILD AGE 12 OR YOUNGER

The County Will Make a PD if:	The Following Combination of Blocks Have Been Checked, and Blocks Have Been Completed as Indicated Below:	
	Block A	HIV Test Performed
	Block B	Positive
	Block D	One or more items checked
	Blocks I and J	Physicians's name, address, and signature.
	Block A	HIV Test Performed
	Block B	Positive
	Block E	One or more of the items checked
	Block G	Birth to attainment of age 1 - One or more of the items checked Age 1 to attainment of age 3 - One or more of the items checked Age 3 to attainment of age 13 - Two or more of the items checked
	Blocks I and J	Physician's name, address, and signature.
	Block A	HIV Test Performed
	Block B	Positive
	Block F	Any two or more items checked
	Block G	Birth to attainment of age 1 - One or more of the items checked Age 1 to attainment of age 3 - One or more of the items checked Age 3 to attainment of age 13 - Two or more of the items checked

Blocks I & J	Physician's name, address, and signature.

Block A	HIV Test Not Performed
OR	
Block B	Negative
Block D	One or more of the following items checked: #8, #9, #10, #13, #14, #17, #19, #21, #23, #26, #28, #29, #31, #32, #33, #34 For items #17, #21, #28, #29, #31, #32, and #33, the child must be over 1 month of age
Blocks I and J	Physician's name, address, and signature.

EXHIBIT 6

CHILD CLAIMS -

CHILD AGE 13 OR OLDER

The County Will Make a PD if:	The Following Combination of Blocks Have Been Checked, and Blocks Have Been Completed as Incicated Below:	
	Block A	HIV Test Performed
	Block B	Positive
	Block D	One or more items checked
	Blocks I and J	Physician's name, address, and signature.
	Block A	HIV Test Performed
	Block B	Positive
	Block C	CD4 (T4) lymphocyte count of 200 or 14% or less
	Block G	At least two of the items checked
	Blocks I and J	Physician's name, address, and signature.
	Block A	HIV Test Performed
	Block B	Positive
	Block E	One or more items checked
	Block G	At least two of the items checked
	Blocks I and J	Physician's name, address, and signature.
	Block A	HIV Test Performed
	Block B	Positive

Block F	Two or more items checked
Block G	At least two of the items checked
Blocks I and J	Physician's name, address, and signature.

Block A	HIV Test Not Performed
OR	
Block B	Negative
Block D	One or more of the following items checked: #8, #13, #14, #17, #19, #21, #23, #26,#28, #29, #31, #32, #33, #34
Blocks I and J	Physician's name, address, and signature.

EXHIBIT 7

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION – AIDS
AUTORIZACION PARA PROPORCIONAR INFORMACION MEDICA – SIDA (AIDS)

Name of Applicant/*Nombre del Solicitante* _____

Social Security Number/*Número del Seguro Social* _____

I.D. nber/*Número de identificación* _____

(Hospital, Clinic, VA, or WCAB)/*(Hospital, Clínica, Administración de Veteranos, o WCAB)*

I authorize
Autorizo a _____

to disclose my medical records or other information for the period beginning _____ and ending _____
que revele mis antecedentes medicos u otra información sobre el periodo de Date/*Fecha* *a* Date/*Fecha*

to the state agency that will review my application for disability benefits under the Social Security Act.
a la dependencia estatal que revisará mi solicitud para beneficios por incapacidad bajo la Ley del Seguro Social.

I authorize a private photocopy company to photocopy such medical records as are needed as evidence in determining my eligibility for such benefits. I have been informed that the private photocopy company will not release any information about me to any person or agency other than the state agency indicated above.

This consent can be withdrawn at anytime; however, it will remain valid for any action taken prior to the request being withdrawn. The duration of this consent shall not be any longer than is reasonably necessary to accomplish the purpose for which it was given, i.e., the final determination of my application for disability benefits (including the appeals process). This consent will then automatically expire without any written request.

I consent to the release of the results of the human immunodeficiency virus (HIV) antibody test and any other indicators of im ne status and medical records and information pertaining to the tment of AIDS or ARC (AIDS-related complex), alcohol and/or drug abuse treatment, and/or psychiatric records under the same conditions as outlined above. I understand that such information cannot be released without my specific consent, except in special circumstances.

I have read the above and fully understand its contents in its entirety and have asked questions about anything that was not clear to me and am satisfied with the answers I have received. I understand that I have the right to receive a copy of this authorization on request.

Autorizo a un negocio privado de fotocopiado para que saque copias fotostáticas de los antecedentes médicos que sean necesario presentar como pruebas para determinar mi elegibilidad para tales beneficios. Se me informó que el negocio privado de fotocopiado no divulgará ninguna información mía a ninguna persona o dependencia que no sea la dependencia estatal que se indica arriba.

Este consentimiento puede ser retirado en cualquier momento; sin embargo, permanecerá en vigor con respecto a cualquier acción que se haya ejercitado antes que se retirara la petición. La vigencia de esta petición, no durará más que lo razonablemente necesario para llevar a cabo el asunto para el cual se dio; esto es, la determinación final de mi solicitud para beneficios de incapacidad (incluyendo el procedimiento de apelaciones). Entonces, este consentimiento expirará automáticamente sin pedirlo por escrito .

Autorizo que los resultados de la prueba para detectar los anticuerpos del virus de inmunodeficiencia humana (VIH) *(HIV - human inmuno-deficiency virus)*, cualesquier otros agentes infeccciosos de inmmunidad, antecedentes médicos, información relacionada con el tratameinto del SIDA (*AIDS*) o de la condición o complejo relacionado a SIDA (CRS) *(ARC - AIDS-related complex)*, tratamientos relacionados con el abuso del alcohol y/o drogas, y los expedientes siquiátricos para que sean proporcionados bajo las mismas condiciones que se indican arriba. Entiendo que tal información no puede proporcionarse a menos que dé mi consentimiento expreso, excepto en circunstancias especiales.

He leído y entiendo perfectamente la información que aparece arriba. He hecho preguntas sobre dudas que tenia y estoy satisfecho con las aclaraciones que me proporcionaron. Entiendo que tengo el derecho de recibir una copia de esta autorización, si asi lo deseo.

_____ _____
Signature of Applicant/*Firma del Solicitante* Date/*Fecha*

_____ _____
Signature of Person Acting in Behalf/*Firma de la Persona que lo Representa* Date/*Fecha*

_____
Street Address/*Dirección*

_____ _____
City/*Ciudad* ZIP Code/*Zona Postal* Telephone/*Teléfono*

To Whom it May Concern: Medical reports released to the state's Disability Evaluation program become part of the applicant's file subject to the provisions of the Federal Privacy Act of 1974 which provides that, upon request, an applicant may have access to those records. A condition of access to medical records is that, at the time access is requested, the applicant must designate a rep ntative to receive, review, and discuss them with the appl nt. It is recommended, but not required, that the representative be a physician or other health service professional.

A Quien Corresponda: Los expedientes médicos proporcionados por el programa estatal de Evaluación de Incapacidades (Disability Evaluation) forman parte del expediente del solicitante de acuerdo a lo estipulado por el Acta Federal de Confidencialidad de 1974 que establece que el solicitante puede tener acceso a esos expedientes si así lo solicita. Una condición para obtener acceso a los expedientes médicos será que, al hacerse la solicitud, el solicitante debe nombrar a un representante para que los reciba, examine, y lo repase con el solicitante. Es recomendable, pero no obligatorio que el representante sea un médico u otro profesionista en el ramo de la salud.