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

DEPARTMENT OF HEALTH SERVICES
714/744 P STREET
P.O. BOX 942732
SACRAMENTO, CA 94234-7320
(916) 657-2941

February [illegible], 1994

MEDI-CAL ELIGIBILITY MANUAL LETTER NO.: 128

TO: All Holders of the Medi-Cal Eligibility Manual

COUNTY PROCEDURES FOR DETERMINING PRESUMPTIVE DISABILITY

Ref.: All County Welfare Directors Letter (ACWDL) No. 92-93.
Medi-Cal Eligibility Manual (MEM) No. 120.

Enclosed are revised procedures to Article 4C of the Medi-Cal Eligibility Manual (MEM).

The purpose of this manual update is to transmit to counties, revised 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) finalized the federal regulations for making PD decisions based on the HIV infection. Counties are to implement these procedures by May 1, 1994 or sooner.

This manual update brings the county PD procedures into conformance with the provisions of the final regulations of HIV infection and includes the revised HIV PD forms, DHS 7035A, Medical Report on Adult With Allegation of Human Immunodeficiency Virus Infection, and DHS 7035C, Medical Report On Child With Allegation of Human Immunodeficiency Virus Infection, (formerly "Physician's Report On Adult With Allegation of Human Immunodeficiency Virus Infection" and "Physician's Report on Child With Allegation Of Human Immunodeficiency Virus Infection").

PLEASE NOTE: These revised procedures supersede the procedures specified in MEM Letter No. 120, dated December 11, 1992; however, the procedures specified in No. 120 should be retained until August 1, 1994, which will be three months following the May 1, 1994 implementation date. If the previous edition of either the DHS 7035A or the 7035C is submitted to the county by the applicant, beneficiary or his/her medical source, during the three months interim period, counties shall use the procedures specified in MEM Letter No. 120 to process the form(s). However, if counties receive the old form(s) following the August 1, 1994 deadline, counties should not process the form(s) as a PD, but shall forward the form(s) directly to the Disability Evaluation Division (DED) for processing.

Background

The SSA revised and simplified their procedures for making decisions based on HIV infection. The following provides counties with an explanation of the major changes:

Highlights for County Revisions

1. The county instructions were reorganized to include specific headings to enable the user to quickly locate the needed information.

2. A cover sheet has been attached to each form and contains instructions to the claimant's medical source explaining how to complete the form, and the form itself has been slightly revised.

3. Several alternatives are given for completing the form.

4. Examples are given of medical professionals who may sign the form(s) and includes information for the county to follow if there is a question about the acceptability of the signature of the form.

5. Instructions are provided for the county to use if the applicant/beneficiary brings the form(s) to the county.

6. Instructions are provided for the county to use if the applicant/beneficiary alleges HIV infection but has no medical source.

7. Step-by-step instructions are provided for the county to use if the applicant/beneficiary alleges HIV infection and has a medical source. It includes information on how to complete the instruction sheet and the HIV PD check-block form. The instructions on the use of the cover letter have been deleted; the form now has an instruction sheet that replaces the cover letter. This subsection also includes information on forms received via FAX.

8. Counties are instructed to appoint an office coordinator to receive the returned HIV form(s), to preserve confidentially of information.

The procedures include the following exhibits intended to assist counties in processing adult and child claims with allegations of HIV infection:

Exhibit 1	--	Form MC 4033 (Disability Listings Update)
Exhibit 2	--	Form DHS 7035A (With Instruction Sheet)
Exhibit 2(a)	--	County Desk Aid for Making a PD Finding in Adult Claims
Exhibit 2(b)	--	EVALUATING COMPLETION OF SECTION D, ITEM 42a "Repeatec Manifestations of HIV Infection"
Exhibit 3	--	Form DHS 7035C (With Instruction Sheet)
Exhibit 3(a)	--	County Desk Aid for Making a PD Finding in Child Claims
Exhibit 4	--	MC 220A "Authorization For Release of Medical Information-AIDS'

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

Procedure Revision	Description
Article 4C	Revised procedures for determining presumptive disability

Filing Instruction:

Remove Pages	Insert Pages
4C-1 through 4C-7	4C-1 through 4C-28
Exhibits 1 through 7	

If you have any questions on this issue, please contact Ms. RaNae Dunne or my staff at (9[illegible]6) 657-0714.

Sincerely,

Original signed by

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 Department of Social Services, Disability Evaluation Division (DSS 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). PD is NOT allowed for retroactive months** (only as of the month of discovery).

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 May 1 1994.

IV. WHEN TO USE THESE PROCEDURES

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

County Responsibility:

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 was based on PD and indicate in the DED packet (under the "CWD Representative Comments" column of the MC 221) if PD was approved. Counties should immediately process cases and grant temporary eligibility upon notification from DED that a case should have been determined PD.

DED Responsibility:

DED will contact the appropriate county liaison, by telephone, if a county initially determined that an applicant did not meet any of the conditions to allow for PD, and DED subsequently determines that the applicant meets PD criteria. DED will indicate the following in the remarks section of the MC 221: "PD decision phoned to CWD liaison; received by (name of contact) on (date)", and they

will initial and date the statement. A photocopy of the MC 221 will then be mailed to the CWD liaison as verification of the PD. DED will process the case as quickly as possible to make a formal determination. If disability is not established when the formal decision is made, DED will indicate in the remark section of the MC 221 as follows: "Previous PD decision not supported by additional evidence".

NOTE: Counties should use the DHS 4033 "Disability Listings Update" to notify the state of any changes to the DED telephone and designated county liaison(s) listing (see exhibit 1). Indicate updates by check mark, next to "Medi-Cal Liaison(s) for Disability issues" on the form. The other choice is for quarterly status listings for pending and closed disability cases (refer to page 4A-14 for details).

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

A. 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 Item G regarding hemiplegia due to a stroke.

B. Allegation of severe mental deficiency (i.e., mental retardation) made by another individual filing on behalf of a claimant who is at least seven years of age. The applicant alleges that the individual attends (or attended) a special school, or special classes in school, because of his or her mental deficiency, or is unable to attend any type of school (or if beyond school age, was unable to attend), and requires care and supervision of routine daily activities (i.e., the individual is dependent upon others for personal needs which is grossly in excess of what would be age-appropriate).

NOTE: Severe mental retardation may be characterized by the inability to comprehend, read or write, communicate, follow directions, and adjust emotionally and socially.

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

D. 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.

E. 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 aids are not totally deaf as some ability to hear is present.

F. 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.

G. 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.

H. Cerebral palsy, muscular dystrophy, or muscle atrophy with marked difficulty in walking requiring the use of two crutches, a walker, or 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.

I. 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.

J. Allegation of Down Syndrome. **NOTE**: Down Syndrome may be characterized by some indication of mental retardation and by abnormal development of the skull (lateral upward slope of the eyes, small ears, protruded tongue, short nose with a flat bridge, small and frequently abnormally aligned teeth); short arms and legs; and hands and feet that tend to be broad and flat.

K. A child, premature at birth (i.e., 37 weeks or less) age 6 months or younger and the birth certificate or other evidence (e.g., hospital admission summary) shows a weight of below 1200 grams (2 pounds 10 ounces) at birth.

L. A diagnosis of Human Immunodeficiency Virus (HIV) infection confirmed by reliable and currently accepted tests with one of the secondary conditions recognized by the Social Security Administration. HIV is characterized by the inability of the body's natural immunity to fight infection and is susceptible to one or more opportunistic diseases, cancers, or other conditions.

Counties may make a finding of PD for any individual with HIV infection whose medical source provides us with information that confirms that the individual's disease manifestations are of listing-level severity, whether or not the individual has been diagnosed as having Acquired Immunodeficiency Syndrome (AIDS).

The diagnosis of HIV must meet certain conditions listed on either the DHS 7035A, Medical Report On Adult With Allegation of Human Immunodeficiency Virus Infection or the DHS 7035C, Medical Report On Child With Allegation of Human Immunodeficiency Virus Infection (refer to exhibits 2 and 3) for a PD. An individual is considered an adult for the purposes of determining PD the day of his/her 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 a medical professional (physician, nurse or other member of a hospital or clinic staff) who can confirm the diagnosis and severity of the HIV disease symptoms. A blank DHS 7035A or DHS 7035C should be provided to either the applicant/beneficiary or physician. **Counties are instructed to appoint a district coordinator to receive the returned HIV form(s), to preserve confidentiality of information.**

THE FOLLOWING PROVIDES COUNTIES WITH SPECIFIC HIV/PD PROCEDURES:

A. POLICY

1. COUNTY — The county may make a finding of PD for individuals

   a. Who allege HIV infection

   AND

   b. Whose medical source provides counties with information that confirms that the individual's disease manifestions are of listing-level severity as outlined in C. below for adults, and D. below, in the case of a child alleging HIV infection.

2. DED — The DED may make a finding of PD at any time that the evidence is sufficient to establish a high degree or probability that the individual will be found disabled.

3. FORMS — Forms used to verify the presence of the disease manifestations are:

Form Used In Claim For An Adult

   a. Form DHS 7035A "Medical Report on Adult With Allegation of HIV Infection", (see exhibit 2).

Form Used In Claim For A Child

b. Form DHS 7035C "Medical Report on Child With Allegation of HIV Infection", (see exhibit 3).

PLEASE NOTE: A cover sheet is attached to each form which contain instructions explaining how to complete the form(s).

4. METHODOLOGY

Form Mailed To Medical Source For Completion And Return

Generally, the county mails a check-block form to the applicant's/beneficiary's medical source for completion and return to the county.

Telephone Or Other Direct Contact

The county may use telephone or other direct contact to verify the presence of the disease manifestations.

Applicant/Beneficiary Brings Completed Form To County

The applicant/beneficiary may directly request his or her medical source to complete the check-block form.

PLEASE NOTE: Copies of the form(s) may be made available to physicians and others upon request.

5. ACCEPTABLE SIGNATURE

Who May Sign The Form

The county will accept completed forms signed by a medical professional (e.g., physician, nurse, or other member of hospital or clinic staff) who is able to confirm the diagnosis and severity of the HIV disease manifestation.

Questionable Signature

If there is any question about the acceptability of the signature, call the physician, hospital, or clinic for verification before making a PD finding. If the signature cannot be verified, follow the procedure in E.2. below.

B. PROCEDURE

1. Claimant Brings Completed Form To County

If the claimant brings the completed form to the county, the county will follow the instructions outlined in B.7 through E. below, as appropriate.

PLEASE NOTE: Handle all HIV cases expeditiously.

2. Claimant Alleges HIV Infection But Has No Medical Source

If the claimant alleges no medical source, the county will:

a. Forward the file to DED.

3. Claimant Alleges HIV Infection And Has A Medical Source

When processing claims for individuals alleging HIV infection and the claimant has a medical source, the county will take the following actions.

Authorization for Release of Medical Information

a. Complete the Form MC 220A "Authorization For Release of Medical Information", and obtain the applicant's/beneficiary's signature, (see exhibit 4).

b. Attach the signed MC 220A to the check-block form.

c. Check the "Medical Release Information" space of the check-block form.

PLEASE NOTE: While the DHS 7035A/DHS 7035C contains an abbreviated medical release, the county should use the MC 220A. The abbreviated medical release is provided if the form is completed without access to an MC 220A.

Process for Completing Section A of the DHS 7035A/DHS 7035C

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

a. Enter the applicant's/beneficiary's medical source's name in the appropriate space.

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

4. Return Envelope

a. Prepare a return envelope using the address of the appropriate county.

b. Include the remark "ATTN: HIV Coordinator" on the return envelope.

PLEASE NOTE: The county will appoint an office coordinator to receive the returned HIV PD form, to preserve confidentiality of information.

5. Mailing Of The DHS 7035A (Adult Form) Or DHS 7035C (Child Form)

a. Mail the DHS 7035A or DHS 7035C, as applicable, with the attached MC 220A to the medical source for completion and return to the county.

b. Include the specially marked return envelope.

6. County Actions Prior To Return Of The Form

The county will not hold the disability folder pending receipt of the form(s), but will flag the packet and forward it to the DED. The county should indicate on the DED packet (under the "CWD Representative Comments" column on the MC 22[illegible]) that PD is pending.

7. Form Returned to County

Upon return of the DHS 7035A or DHS 7035C, as applicable, the county will :

a. Review the form,

b. Verify that the form is properly signed (refer to A.5. above),

AND

c. Make a finding of PD if the appropriate combination of blocks has been checked or completed as specified in C. below for an adult, or in D. below, for a child.

d. Prior to forwarding the form(s) 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. File Has Been Forwarded To The DED

Upon return of the completed form, the county will make a finding of PD, if appropriate, even if the medical file has already been forwarded to the DED.

9. Telephone Or Other Direct Contact Is Used

If telephone or other direct contact is used, the county should:

a. Complete the appropriate blocks of the DHS 7035A or DHS 7035C.

b. Indicate at the signature block "Per telephone conversation of ____(date)____ with (medical source's name)".

c. Refer to C. below for an adult or D. below for a child.

10. Medical Evidence Of Record In The County

If medical evidence of record is received in the county, along with the completed form(s), make the PD finding, if applicable, and forward the evidence to the DED. Counties should indicate the status of the PD determination either on the MC 221 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.

11. Form Received Via FAX

a. If the form was transmitted directly to the county from the medical source, determine the quality of the paper of the FAXed material.

b. If the FAXed material is of poor quality (paper darkened by copier)

- Photocopy the FAX form because the quality of FAX output deteriorates over a period of time.
- Retain the photocopied form in file.
- Destroy the original FAXed form.

c. If the FAXed material is of acceptable quality, retain the material.

IMPORTANT: If there is any question about whether the medical source transmitted the form, telephone the medical source to verify that the evidence received via FAX was, in fact, transmitted from the medical source. DOCUMENT THE TELEPHONE CONTACT IN THE CASE FILE.

C. PROCEDURE - EVALUATING THE COMPLETED DHS 7035A

A finding of PD will be made where the appropriate blocks have been checked or completed on the DHS 7035A as indicated in 1. or 2. below.

1. At Least One Disease Has Been Checked In Section C

The county will make a PD finding if:

a. Either block in Section B has been checked,

AND

b. Any item has been checked in Section C,

AND

c. Section F has been completed and Section G has been signed.

2. Repeated Manifestations of HIV, Section D Has Been Completed

The county will make a PD finding if:

a. Section B has been checked,

AND

b. Section D (both 42a and b) has been completed,

- Item 42a must indicate the presence of "repeated manifestations of HIV infection."

ALERT: When we refer to "manifestations of HIV infection", we mean conditions that do not meet the findings specified in Section C.

"Repeated" manifestations means:

- that a condition or combinations of conditions occurs an average of 3 times a year, or
- once every 4 months, each lasting 2 weeks or more; or does not last for 2 weeks, but occurs substantially more frequently than 3 times in a year or once every 4 months; or
- occurs less often than an average of 3 times a year or once every 4 months but lasts substantially longer than 2 weeks.
- Item 42b - at least one of the criteria shown must be checked.

AND

c. Section F has been completed and Section G has been signed.

NOTE: Exhibit 2(a) provides counties with a desk aid for making a PD finding in adult claims. Exhibit 2(b) provides specific criteria for evaluating repeated manifestations of HIV infection which is found in section D.; item 42a of the DHS 7035A.

ALERT: If the county has any questions as to whether the manifestations listed are sufficient to support a PD, the county should send the form to the DED for the PD finding. A finding of PD will be made where the appropriate blocks have been checked or completed on the DHS 7035A as indicated in 1. or 2. above.

D. PROCEDURE - EVALUATING THE COMPLETED DHS 7035C

A finding of PD will be made where the appropriate blocks have been checked or completed on the DHS 7035C as indicated in 1. or 2. below.

1. At Least One Disease Has Been Checked In Section C

The county will make a PD finding if:

a. Either block in Section B. has been checked,

AND

b. Any item has been checked in Section C.,

ALERT: Section C; Item 6 is used only for a child less than 13 years of age. Do not use item 6 for children age 13 and over.

AND

c. Section F has been completed and Section G. has been signed.

2. Other Manifestations Of HIV, Section D. Has Been Completed

The county will make a PD finding if:

a. Either block in Section B. has been checked,

AND

b. Section D; Item 48a. has been completed,

AND

Either item 48b., c., or d. (depending on the child's age) has been completed.

ALERT: Items 48b. and 48c. require only one block to be checked. Item 48d. requires two blocks to be checked.

AND

c. Section F has been completed and Section G. has been signed.

NOTE: Exhibit 3(a) provides counties with a desk aid for making a PD finding in a child's claims.

ALERT: If the county has any questions as to whether the manifestations listed are sufficient to support a PD, the county should send the form to the DED for the PD finding. A finding of PD will be made where the appropriate blocks have been checked or completed on the DHS 7035A as indicated in 1. or 2. above.

E. PROCEDURE PD FINDING

1. County Is Able To Make PD Finding

a. After the PD finding has been made following the procedures outlined in C. and D. above, the county will complete the packet and forward it to DED.

2. County Unable To Make A Finding Of PD

b. If the folder has been forwarded to DED, the county will:

- Advise DED of the action taken; and
- Forward the form to DED for association with the packet.

If the county is unable to make a finding of PD because the form(s) has not been appropriately completed, or for any other reason, forward the form(s), and the folder, if appropriate, to the DED. This will allow DED to develop the case further.

EXHIBIT 1

STATE OF CALIFORNIA - HEALTH AND WELFARE AGENCY

DEPARTMENT OF HEALTH SERVICES

DISABILITY LISTINGS UPDATE

_____ MEDI-CAL LIAISON(S) FOR DISABILITY ISSUES

_____ MEDI-CAL LIAISON(S) FOR QUARTERLY STATUS LISTINGS FOR PENDING AND CLOSED DISABILITY CASES

(PLEASE INDICATE WHICH LIST IS TO BE UPDATED WITH A CHECK MARK)

PLEASE USE THIS FORM TO TRANSMIT THE NAME OF YOUR COUNTY'S REPRESENTATIVE, OR IN COUNTIES WHERE MULTIPLE CONTACTS WILL BE NECESSARY, PLEASE PROVIDE THE SAME INFORMATION FOR EACH REPRESENTATIVE ON A SEPARATE FORM. IT WOULD BE APPRECIATED IF THE INFORMATION IS PRINTED OR TYPED.

COUNTY:_____

LIAISON:_____

LIAISON'S POSITION TITLE:_____

LIAISON'S TELEPHONE NUMBER:_____

ALTERNATIVE TELEPHONE NUMBER:_____

OFFICE ADDRESS: _____

_____

_____

_____

_____

RETURN TO: Department of Health Services
Medi-Cal Eligibility Branch
Attn: Unit B Clerical Supervisor
714 P Street, Room 1376
P.O. Box 942732
Sacramento, CA 94234-7320

MC 4033 (8/93)

EXHIBIT 2

STATE OF CALIFORNIA - HEALTH AND WELFARE AGENCY DEPARTMENT OF HEALTH SERVICES

MEDICAL SOURCE INSTRUCTION SHEET FOR COMPLETION OF ATTACHED DHS 7035A (Medical Report On Adult With Allegation Of Human Immunodeficiency Virus (HIV) Infection)

Your patient, identified in section A of the attached form, has filed a claim 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 Heath Services medical release (MC 220A) signed by your patient 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.

IV. HOW TO COMPLETE THE FORM:

- If you receive the form from your patient 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 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 from your patient without a return envelope, give the completed, signed form back to your patient 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.
- 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 a "marked" degree in any of the areas listed. See below for an explanation of the term "marked."

SPECIAL TERMS USED IN SECTION D

WHAT WE MEAN BY "REPEATED" MANIFESTATIONS OF HIV INFECTION: *(See item 42.a)*

"Repeated" means that a condition or combination of conditions:

- Occurs an average of 3 times a year, or once every 4 months, each lasting 2 weeks or more; or
- Does not last for 2 weeks, but occurs substantially more frequently than 3 times in a year or once every 4 months; or
- Occurs less often than an average of 3 times a year or once every 4 months but lasts substantially longer than 2 weeks.

WHAT WE MEAN BY "MANIFESTATIONS OF HIV INFECTION": *(See item 42.a)*

- "Manifestations of HIV infection" may include:

  Any condition listed in section C, but without the findings specified there (e.g., carcinoma of the cervix not meeting the criteria shown in item 22 of the form, diarrhea not meeting the criteria shown in item 33 of the form); or any other condition that is not listed in section C (e.g., oral hairy leukoplakia, myositis).

- Manifestations of HIV must result in significant, documented, symptoms and signs (e.g., fatigue, fever, malaise, weight loss, pain, night sweats).

Continued on the reverse

DHS 7035A-Coversheet (1/94)

EXHIBIT 2 (cont.)

WHAT WE MEAN BY "MARKED" LIMITATION OR RESTRICTION IN FUNCTIONING: *(See item 4*

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

WHAT WE MEAN BY "ACTIVITIES OF DAILY LIVING": *(see item 42.b)*

- Activities of daily living include, but are not limited to, such activities as doing household chores, gro ning and hygiene, using a post office, taking public transportation, and paying bills.
- **EXAMPLE**: An individual with HIV infection who, because of symptoms such as pain imposed by the il ss or its treatment, is not able to maintain a household or take public transportation on a sustained basis or without sistance (even though he or she is able to perform some self-care activities) would have marked limitation of activit s of daily living.

WHAT WE MEAN BY "SOCIAL FUNCTIONING": *See item 42.b)*

- Social functioning includes the capacity to interact appropriately and communicate effectively with others.
- **EXAMPLE**: An individual with HIV infection who, because of symptoms or a pattern of exacerbation anc emission caused by the illness or its treatment, cannot engage in social interaction on a sustained basis (even thoug e or she is able to communicate with close friends or relatives) would have marked difficulty maintaining social functic ng.

WHAT WE MEAN BY "COMPLETING TASKS IN A TIMELY MANNER": *(See item 42.b)*

- Completing tasks in a timely manner involves the ability to sustain concentration, persistence, or pace to pe nit timely completion of tasks commonly found in work settings.
- **EXAMPLE**: An individual with HIV infection who, because of HIV-related fatigue or other symptoms, is nable to sustain concentration or pace adequate to complete simple work-related tasks (even though he or she is le to do routine activities of daily living) would have marked difficulty completing tasks.

PRIVACY ACT NOTICE: The Department of Health Services (DHS) is authorized to collect the information or his form under sections 205(a), 233(d) and 1633(e)(1) of the Social Security Act. The information on this form is needed l DHS to make a decision on the named claimant's application for Medi-Cal based on disability. While giving us the informat on this form is voluntary, failure to provide all or part of the requested information could prevent an accurate or timely decis on the named claimant's application. Although the information you furnish is almost never used for any purpose other than making a determination about the claimant's disability, such information may be disclosed by the DHS as follows: (1) to ena a third party or agency to assist DHS 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 o records with those of other Federal, State, or local government agencies. Many agencies may use matching programs find or prove that a person qualifies for benefits paid by the Federal government. The law allows us to do this even if y do not agree to it.

Federal law governing Medicaid requires that medical information on applicants and beneficiaries be kept co dential. (42 United States Code, section 1396a (a) (7).) The regulations implementing this law deal with the disclosure of ir rmation collected and maintained by state Medicaid agencies. (42 California Federal Register, sections 431.300 et seq.)

DHS 7035A-Coversheet (1/94)

EXHIBIT 2 (cont.)

STATE OF CALIFORNIA - HEALTH AND WELFARE AGENCY DEPARTMENT OF HEALTH SERVICES

MEDICAL REPORT ON ADULT 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 220A, "Authorization to Release Medical Information" to the Department of Health Services, 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.

CLAIMANT'S SIGNATURE *(Required only if Form MC 220A is NOT attached)* | DATE

A. IDENTIFYING INFORMATION

MEDICAL SOURCE'S NAME | CLAIMANT'S NAME

CLAIMANT'S SSN | CLAIMANT'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 non-typhoid
5. ☐ **SYPHILIS OR NEUROSYPHILIS** (e.g., meningovascular syphilis) resulting in neurologic or other sequelae
6. ☐ **MULTIPLE OR RECURRENT BACTERIAL INFECTION(S),** including pelvic inflammatory disease, requiring hospitalization or intravenous antibiotic treatment 3 or more times in 1 year

FUNGAL INFECTIONS

7. ☐ **ASPERGILLOSIS**
8. ☐ **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
9. ☐ **COCCIDIOIDOMYCOSIS,** at a site other than the lungs or lymph nodes
10. ☐ **CRYPTOCOCCOSIS,** at a site other than the lungs (e.g., cryptococcal meningitis)
11. ☐ **HISTOPLASMOSIS,** at a site other than the lungs or lymph nodes
12. ☐ **MUCORMYCOSIS**

PROTOZOAN OR HELMINTHIC INFECTIONS

13. ☐ **CRYPTOSPORIDIOSIS, ISOSPORIASIS OR MICROSPORIDIOSIS,** with diarrhea lasting for 1 month or longer
14. ☐ **PNEUMOCYSTIS CARINII PNEUMONIA OR EXTRAPULMONARY PNEUMOCYSTIS CARINII INFECTION**
15. ☐ **STRONGYLOIDIASIS,** extra-intestinal
16. ☐ **TOXOPLASMOSIS** of an organ other than the liver, spleen, or lymph nodes

VIRAL INFECTIONS

17. ☐ **CYTOMEGALOVIRUS DISEASE,** at a site other than the liver, spleen, or lymph nodes
18. ☐ **HERPES SIMPLEX VIRUS** causing mucocutaneous infection (e.g., oral, genital, perianal) lasting for 1 month or longer; or infection at a site other than the skin or mucous membranes (e.g., bronchitis, pneumonitis, esophagitis, or encephalitis); or disseminated infection
19. ☐ **HERPES ZOSTER,** disseminated or with multidermatomal eruptions that are resistant to treatment
20. ☐ **PROGRESSIVE MULTIFOCAL LEUKOENCEPHALOPATHY**

EXHIBIT 2 (cont.)

21. ☐ **HEPATITIS**, resulting in chronic liver disease manifested by appropriate findings (e.g., persistent ascites, bleeding esophageal varices, hepatic encephalopathy)

MALIGNANT NEOPLASMS

22. ☐ **CARCINOMA OF THE CERVIX**, invasive, FIGO stage II and beyond
23. ☐ **KAPOSI'S SARCOMA**, with extensive oral lesions; or involvement of the gastrointestinal tract, lungs, or other visceral organs; or involvement of the skin or mucous membranes with extensive fungating or ulcerating lesions not responding to treatment
24. ☐ **LYMPHOMA** of any type (e.g., primary lymphoma of the brain, Burkitt's lymphoma, immunoblastic sarcoma, other non-Hodgkin's lymphoma, Hodgkin's disease)
25. ☐ **SQUAMOUS CELL CARCINOMA OF THE ANUS**

SKIN OR MUCOUS MEMBRANES

26. ☐ **CONDITIONS OF THE SKIN OR MUCOUS MEMBRANES**, with extensive fungating or ulcerating lesions not responding to treatment (e.g., dermatological conditions such as eczema or psoriasis, vulvovaginal or other mucosal candida, condyloma caused by human papillomavirus, genital ulcerative disease)

HEMATOLOGIC ABNORMALITIES

27. ☐ **ANEMIA** (hematocrit persisting at 30 percent or less), requiring one or more blood transfusions on an average of at least once every 2 months
28. ☐ **GRANULOCYTOPENIA**, with absolute neutrophil counts repeatedly below 1,000 cells/mm³ and documented recurrent systemic bacterial infections occurring at least 3 times in the last 5 months
29. ☐ **THROMBOCYTOPENIA**, with platelet counts repeatedly below 40,000/mm³ with at least one spontaneous hemorrhage, requiring transfusion in the last 5 months; or with intracranial bleeding in the last 12 months

NEUROLOGICAL ABNORMALITIES

30. ☐ **HIV ENCEPHALOPATHY**, characterized by cognitive or motor dysfunction that limits function and progresses
31. ☐ **OTHER NEUROLOGICAL MANIFESTA IONS OF HIV INFECTION** (e.g., peripheral neuropath , with significant and persistent disorganizatio of motor function in 2 extremities resulting in sus ined disturbance of gross and dexterous mo ments, or gait and station

HIV WASTING SYNDROME

32. ☐ **HIV WASTING SYNDROME**, characte ed by involuntary weight loss of 10 percent or ore of baseline (or other significant involuntary weight l s) and, in the absence of a concurrent illness that cou l explain the findings, involving: chronic diarrhea wit ? or more loose stools daily lasting for 1 month or longe or chronic weakness and documented fever great than 38°C (100.4°F) for the majority of 1 month or nger

DIARRHEA

33. ☐ **DIARRHEA**, lasting for 1 month or long , resistant to treatment, and requiring intravenous hy ation, intravenous alimentation, or tube feedin

CARDIOMYOPATHY

34. ☐ **CARDIOMYOPATHY** (chronic heart fail e, or cor pulmonale, or other severe cardiac abn mality not responsive to treatment)

NEPHROPATHY

35. ☐ **NEPHROPATHY**, resulting in chronic re al failure

INFECTIONS RESISTANT TO TREAT IENT OR REQUIRING HOSPITALIZATI N OR INTRAVENOUS TREATME IT 3 OR MORE TIMES IN 1 YEA R

36. ☐ **SEPSIS**
37. ☐ **MENINGITIS**
38. ☐ **PNEUMONIA** (non-PCP)
39. ☐ **SEPTIC ARTHRITIS**
40. ☐ **ENDOCARDITIS**
41. ☐ **SINUSITIS**, radiographically document l

NOTE: If you have checked any of the boxes in section C, proceed to section E if you have any remarks you w h 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 ir tructions 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.

EXHIBIT 2 (cont.)

D. OTHER MANIFESTATIONS OF HIV INFECTION

42. a. **REPEATED MANIFESTATIONS OF HIV INFECTION,** including diseases mentioned in section C, items 1-4, but without the specified findings described above, or other diseases, resulting in significant, documented, symptoms or signs (e.g., fatigue, fever, malaise, weight loss, pain, night sweats).

Please specify:

1. The manifestations your patient has had;
2. The number of episodes occurring in the same 1-year period; and
3. The approximate duration of each episode

Remember, your patient need not have the same manifestation each time to meet the definition of repeated manifestations; but, all manifestations used to meet the requirement must have occurred in the same 1-year period. (See attached instructions for the definition of repeated manifestations.)

If you need more space, please use section E.

MANIFESTATIONS:	NO. OF EPISODES IN THE SAME 1 YEAR PERIOD:	DURATION OF EACH EPISODE:
EXAMPLE: Diarrhea	3	1 month each

AND

b. **ANY OF THE FOLLOWING:**

- ☐ Marked restriction of **ACTIVITIES OF DAILY LIVING**; or
- ☐ Marked difficulties in maintaining **SOCIAL FUNCTIONING**; or
- ☐ Marked difficulties in completing tasks in a timely manner due to deficiencies in **CONCENTRATION, PERSISTENCE, OR PACE.**

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'S NAME AND ADDRESS *(Print or type)*

TELEPHONE NUMBER (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 (e.g., physician, R.N.) OF PERSON COMPLETING THIS FORM

▶

FOR OFFICAL USE ONLY

- ☐ COUNTY OFFICE DISPOSITION:
- ☐ DISABILITY EVALUATION DIVISION DISPOSITION:

DHS 7035A (1/94)

EXHIBIT 2(a)

COUNTY DESK AID FOR MAKING A PD FINDING IN ADULT CLAIMS

The County Will Make A PD Finding If:	The Following Combination of Blocks Have Been Completed, And The Blocks Have Been Completed as Indicated Below:	
	Section B	Either block has been checked
	Section C	One or more blocks have been checked
	Section F	Medical source's name and address have been completed
	Section G	Signature block has been completed
	OR	
	Section B	Either block has been checked
	Section D	Item 42a - has been completed showing manifestations of HIV infection that are repeated as shown in Exhibit 3
		Item 42b - one or more blocks have been checked
	Section F	Medical source's name and address have been completed
	Section G	Signature block has been completed

EXHIBIT 2(b)

EVALUATING COMPLETION OF SECTION D; ITEM 42a. - "REPEATED MANIFESTATIONS OF HIV INFECTION" OF ADULT CLAIM

IF: HIV manifestations listed in Section D include diseases mentioned in Section C; items 1-41 of the DHS 7035A, but without the specified findings discussed there (e.g., carcinoma of the cervix not meeting the criteria shown in item 22 of the form, diarrhea not meeting the criteria shown in item 33 of the form); or any other manifestations of HIV not listed in Section C. (e.g., oral leukoplakia, myositis)*

AND:	AND:	THEN:
Number of Episodes of HIV Manifestations In The Same 1-Year Period is:	Duration of Each Episode is:	
At least 3	At least 2 weeks	Requirement is me
Substantially more than 3	Less than 2 weeks	Requirement is me
Less than 3	Substantially more than 2 weeks	Requirement is me
Unable to determine	Unable to determine	Refer to DED

*REMINDER: If there is any question as to whether the manifestation listed is a manifest ition of HIV, refer to DED

ALERT: The same manifestations need not be represented in each episode.

Examples

Manifestation(s)	Episodes	Duration	Requiremen Is Met?
Anemia	2	2 months each time	Yes
Diarrhea Bacterial Infection	2 1	3 weeks each time 2 ½ weeks	Yes[2]
Pneumonia	2	1 week each time	No[3] (Refer to DED)

1 The requirement is met based on less than 3 episodes of anemia, each lasting substantially more than 2 weeks.

2 The requirement is met based on a total of 3 episodes of diarrhea and bacterial infection, each lasting at least 2 weeks.

3 The requirement is not met because there are less than 3 episodes of pneumonia and each episode did not last substantially more than 2 weeks.

EXHIBIT 3

STATE OF CALIFORNIA - HEALTH AND WELFARE AGENCY DEPARTMENT OF HEALTH SERVICES

MEDICAL SOURCE INSTRUCTION SHEET FOR COMPLETION OF ATTACHED DHS 7035C (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 Services medical release (MC 220A) 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 manifestation(s) 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 "MANIFESTATION(S) OF HIV INFECTION": *(See item 48.a)*

"Manifestation(s) of HIV infection" may include:

Any condition 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 condition that is not listed in section C (e.g., oral hairy leukoplakia, hepatomegaly).

Continued on the reverse ➡

EXHIBIT 3 (cont.)

WHAT WE MEAN BY "MARKED": *(See Item 48.d - 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 Services (DHS) 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 DHS to make a decision on the named claimant'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 claimant's application. Although the information you furnish is almost never used for any purpose other than making a determination about the claimant's disability, such information may be disclosed by the DHS as follows: (1) to enable a third party or agency to assist DHS 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, or 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 1396a (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.)

DHS 7035C-Coversheet (1/94)

EXHIBIT 3 (cont.)

STATE OF CALIFORNIA - HEALTH AND WELFARE AGENCY

DEPARTMENT OF HEALTH SERVICES

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 220A, "Authorization to Release Medical Information" to the Department of Health Services, 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 the child's treatment for human immunodeficiency virus (HIV) infection.

CLAIMANT'S PARENT OR GUARDIAN'S SIGNATURE *(Required only if Form MC 220A is NOT attached)*	DATE

A. IDENTIFYING INFORMATION

MEDICAL SOURCE'S NAME	CLAIMANT'S NAME
CLAIMANT'S SSN	**CLAIMANT'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 non-typhoid
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 of an internal organ or body cavity (excluding otitis media or superficial skin or mucosal abscesses) occurring 2 or more times in 2 years
7. ☐ **MULTIPLE OR RECURRENT BACTERIAL INFECTION(S)** including pelvic inflammatory disease, requiring hospitalization or intravenous antibiotic treatment 3 or more times in 1 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
10. ☐ **COCCIDIOIDOMYCOSIS**, at a site other than the lungs or lymph nodes
11. ☐ **CRYPTOCOCCOSIS**, at a site other than the lungs (e.g., cryptococcal meningitis)
12. ☐ **HISTOPLASMOSIS**, at a site other than the lungs or lymph nodes
13. ☐ **MUCORMYCOSIS**

PROTOZOAN OR HELMINTHIC INFECTIONS

14. ☐ **CRYPTOSPORIDIOSIS, ISOSPORIASIS, OR MICROSPORIDIOSIS**, with diarrhea lasting for 1 month or longer
15. ☐ **PNEUMOCYSTIS CARINII PNEUMONIA OR EXTRAPULMONARY PNEUMOCYSTIS CARINII INFECTION**
16. ☐ **STRONGYLOIDIASIS**, extra-intestinal
17. ☐ **TOXOPLASMOSIS** of an organ other than the liver, spleen, or lymph nodes

VIRAL INFECTIONS

18. ☐ **CYTOMEGALOVIRUS DISEASE**, at a site other than the liver, spleen, or lymph nodes
19. ☐ **HERPES SIMPLEX VIRUS** causing mucocutaneous infection (e.g., oral, genital, perianal) lasting for 1 month or longer; or infection at a site other than the skin or mucous membranes (e.g., bronchitis, pneumonitis, esophagitis, or encephalitis); or disseminated infection
20. ☐ **HERPES ZOSTER**, disseminated or with multidermatomal eruptions that are resistant to treatment

DHS 7035C (1/94)

EXHIBIT 3 (cont.)

21. ☐ **PROGRESSIVE MULTIFOCAL LEUKOENCEPHALOPATHY**

22. ☐ **HEPATITIS**, resulting in chronic liver disease manifested by appropriate findings (e.g., intractable ascites, esophageal varices, hepatic encephalopathy)

MALIGNANT NEOPLASMS

23. ☐ **CARCINOMA OF THE CERVIX**, invasive, FIGO stage II and beyond

24. ☐ **KAPOSI'S SARCOMA**, with extensive oral lesions; or involvement of the gastrointestinal tract, lungs, or other visceral organs; or involvement of the skin or mucous membranes with extensive fungating or ulcerating lesions not responding to treatment

25. ☐ **LYMPHOMA** of any type (e.g., primary lymphoma of the brain, Burkitt's lymphoma, immunoblastic sarcoma, other non-Hodgkin's lymphoma, Hodgkin's disease)

26. ☐ **SQUAMOUS CELL CARCINOMA OF THE ANUS**

SKIN OR MUCOUS MEMBRANES

27. ☐ **CONDITIONS OF THE SKIN OR MUCOUS MEMBRANES**, with extensive fungating or ulcerating lesions not responding to treatment (e.g., dermatological conditions such as eczema or psoriasis, vulvovaginal or other mucosal candida, condyloma caused by human papillomavirus, genital ulcerative disease)

HEMATOLOGIC ABNORMALITIES

28. ☐ **ANEMIA** (hematocrit persisting at 30 percent or less), requiring one or more blood transfusions on an average of at least once every 2 months

29. ☐ **GRANULOCYTOPENIA**, with absolute neutrophil counts repeatedly below 1,000 cells/mm³ and documented recurrent systemic bacterial infections occurring at least 3 times in the last 5 months

30. ☐ **THROMBOCYTOPENIA**, with platelet count of 40,000/mm³ or less despite prescribed therapy, or recurrent upon withdrawal of treatment; or platelet counts repeatedly below 40,000/mm³ with at least one spontaneous hemorrhage, requiring transfusion, in the last 5 months; or with intracranial bleeding in the last 12 months

NEUROLOGICAL MANIFESTATIONS OF HIV INFECTION (e.g., HIV ENCEPHALOPATHY, PERIPHERAL NEUROPATHY) RESULTING IN:

31. ☐ **LOSS OF PREVIOUSLY ACQUIRED, OR MARKED DELAY IN ACHIEVING, DEVELOPMENTAL MILESTONES OR INTELLECTUAL ABILITY** (including the sudden acquisition of a new learning disability)

32. ☐ **IMPAIRED BRAIN GROWTH** (acquired microcephaly or brain atrophy)

33. ☐ **PROGRESSIVE MOTOR DYSFUNCTION** affecting gait and station or fine and gross motor skills

GROWTH DISTURBANCE WITH:

34. ☐ **INVOLUNTARY WEIGHT LOSS (OR FAILURE TO GAIN WEIGHT AT AN APPROPRIATE RATE FOR AGE) RESULTING IN A FALL OF 15 PERCENTILES** from established growth curve (on standard growth charts) that persists for 2 months or longer

35. ☐ **INVOLUNTARY WEIGHT LOSS (OR FAILURE TO GAIN WEIGHT AT AN APPROPRIATE RATE FOR AGE) RESULTING IN A FALL TO BELOW THE THIRD PERCENTILE** from established growth curve (on standard growth charts) that persists for 2 months or longer

36. ☐ **INVOLUNTARY WEIGHT LOSS GREATER THAN 10 PERCENT OF BASELINE** that persists for 2 months or longer

37. ☐ **GROWTH IMPAIRMENT**, with fall of greater than 15 percentiles in height which is sustained; or fall to, or persistence of, height below the third percentile

DIARRHEA

38. ☐ **DIARRHEA**, lasting for 1 month or longer, resistant to treatment, and requiring intravenous hydration, intravenous alimentation, or tube feeding

CARDIOMYOPATHY

39. ☐ **CARDIOMYOPATHY** (chronic heart failure; or other severe cardiac abnormality not responsive to treatment)

PULMONARY CONDITIONS

40. ☐ **LYMPHOID INTERSTITIAL PNEUMONIA/PULMONARY LYMPHOID HYPERPLASIA** (LIP/PLH complex), with respiratory symptoms that significantly interfere with age-appropriate activities, and that cannot be controlled by prescribed treatment

NEPHROPATHY

41. ☐ **NEPHROPATHY**, resulting in chronic renal failure

INFECTIONS RESISTANT TO TREATMENT OR REQUIRING HOSPITALIZATION OR INTRAVENOUS TREATMENT 3 OR MORE TIMES IN 1 YEAR

42. ☐ **SEPSIS**

43. ☐ **MENINGITIS**

44. ☐ **PNEUMONIA** (non-PCP)

45. ☐ **SEPTIC ARTHRITIS**

46. ☐ **ENDOCARDITIS**

47. ☐ **SINUSITIS**, radiographically documented

EXHIBIT 3 (cont.)

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 intruction 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 MANIFESTATION(S) OF HIV INFECTION

48. a. **ANY MANIFESTATION(S) OF HIV INFECTION INCLUDING ANY DISEASES LISTED IN SECTION C, items 1-47, but without the specified findings described above, or any other manifestation(s) of HIV infection; please specify type of manifestation(s):**

_____

_____

_____

_____

AND ANY OF THE FOLLOWING FUNCTIONAL LIMITATION(S), COMPLETE ONLY THE ITEMS FOR THE CHILD'S PRESENT AGE GROUP.

b. BIRTH TO ATTAINMENT OF AGE 1 – 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 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
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 6 months to participate in vocal, visual, and motoric exchanges (including facial expressions); 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
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).

c. AGE 1 TO ATTAINMENT OF AGE 3 – 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.

d. 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.

EXHIBIT 3 (cont.)

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'S NAME AND ADDRESS *(Print or type)*	TELEPHONE NUMBER (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 (e.g., physician, R.N.) OF PERSON COMPLETING THIS FORM

▶

FOR OFFICIAL USE ONLY

☐ COUNTY OFFICE DISPOSITION:

☐ DISABILITY EVALUATION DIVISION DISPOSITION:

EXHIBIT 3(a)

COUNTY DESK AID FOR MAKING A PD FINDING IN CHILD CLAIMS

The County Will Make A PD Finding If:	The Following Combination of Blocks Have Been Completed, AND The Blocks Have Been Completed as Indicated Below:	
	Section B	Either block has been checked
	Section C	One or more blocks have been checked **ALERT:** Item 6 applies only to a child less than 13 years of age
	Section F	Medical source's name and address have been completed
	Section G	Signature block has been completed
	OR	
	Section B	Either block has been checked
	Section D	Item 48 - has been completed AND **Birth to attainment of age 1** - One or more of the blocks in **item 48b** has been checked, OR **Age 1 to attainment of age 3** - One or more of the blocks in **item 48c** has been checked, OR

EXHIBIT 3(a)(cont.)

	Age 3 to attainment of age 18 - At least two of the blocks in item **48d** have been checked
	ALERT: The appropriate item 48b., c., or d. should be checked based on the child's age
Section F	Medical source's name and address have been completed
Section G	Signature block has been completed

EXHIBIT 4

State of California - Health and Welfare Agency — Department of Health Services

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. Number/*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 _____ (Date/*Fecha*) and ending _____ (Date/*Fecha*)
que revele mis antecedentes médicos u otra información sobre el periodo de *a*

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 immune status and medical records and information pertaining to the treatment 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 mia 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, permanecera en vigor con respecto a cualquier acción que se haya ejercitado antes que se retirara la petición. La vigencia de esta petición, no durará mas 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 immunodeficiency virus)*, cualesquier otros agentes infecciosos de inmmunidad, antecedentes medicos, información relacionada con el tratamiento del SIDA (*AIDS*) o de la condición o complejo relacionado al 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 tenía y estoy satisfecho con las aclaraciones que me proporcionaron. Entiendo que tengo el derecho de recibir una copia de esta autorización, si así 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 representative to receive, review, and discuss them with the applicant. 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 medicos sera 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 profesional en el ramo de la salud.

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