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

DEPARTMENT OF HEALTH SERVICES
714/744 P STREET
BOX 942732
AMENTO, CA 94234-7320

(916) 657-2941

May 27, 1994

MEDI-CAL ELIGIBILITY MANUAL LETTER NO. 132

TO: All Holders of the Medi-Cal Eligibility Manual

MEDI-CAL ELIGIBILITY MANUAL (MEM) PROCEDURES ON DISABILITY

REVISIONS TO THE MEDI-CAL ELIGIBILITY MANUAL

Enclosed are revisions to the Medi-Cal Eligibility Manual (MEM) procedures pertaining to disability which have been revised and relocated to Article 22. Article 22 is dedicated solely to disability issues. Disability procedures formerly found in Articles 4A through 4G should be removed in their entirety and destroyed. Articles 4H through 4S will not be renumbered; hereafter, Article 4 will begin with 4H.

All counties should implement Article 22 procedures no later than October 1, 1994.

The language and format in Article 22 have been simplified, moving away from the traditional narrative presentation to a more concise, direct approach. An Index is provided by subject matter so that subjects may be easily located in sections where they are discussed. A Glossary of commonly used acronyms is also provided and found after the Index.

The term "client" is used throughout Article 22 to represent both an applicant and a beneficiary. In situations where a procedure or policy refers only to an applicant or only to a beneficiary, the terms "applicant" or "beneficiary" are specified.

MEDI-CAL APPLICATION BASED ON DISABILITY (MABD) COMMITTEE

Article 22 represents the major accomplishment of the Medi-Cal Application Based on Disability (MABD) Committee to update and reorganize disability policies and procedures. The Committee includes representatives from the county Welfare Departments (CWD), the State Programs Branch-Disability Evaluation Division (SP-DED) of the state Department of Social Services, and the Medi-Cal Eligibility Branch (MEB) of the state Department of Health Services (DHS).

FOUR MAJOR PARTS FOUND IN ARTICLE 22

PART I	**22A**	Introduction to the Disability Program
PART II	**22B**	Agencies Involved in the Disability Evaluation Process
PART III	**22C**	County Welfare Department Procedures
PART IV	**22D**	Disability Evaluation Division Procedures

Articles 22A, 22B and 22D are short and largely informational. In contrast, Article 22C is extensive, having a significant impact on CWD's actions. Article 22C specifies the actions CWDs must take when processing Medi-Cal applications based on disability.

NOTE: Significant changes to the MEM procedures are underlined below and on subsequent pages.

PART I: 22A -- INTRODUCTION TO THE DISABILITY PROGRAM

1.	Identifies	the Social Security Administration's (SSA's) definition of disability.
2.	Specifies	the differences between Title II (RSDI) and Title XVI (SSI).
3.	Discusses	state requirements for disability for Medi-Cal purposes.
4.	Introduces	the concept of Substantial Gainful Activity as part of the finding of disability.

PART II: 22B -- AGENCIES INVOLVED IN THE DISABILITY EVALUATION PROCESS

1.	Specifies	the roles of SSA, the Health Care Financing Administration, DHS, SP-DED and CWD.
2.	Lists	the responsibilities of the agencies involved in the disability evaluation process.

PART III: 22C -- CWD PROCEDURES

22C provides a comprehensive view of CWD activities required in processing Medi-Cal applications based on disability and is divided into subsections C-1 to C-9. These subsections present a sequential progression of activities in processing a disability claim.

C-1	Referring Disability Applications to SSA or SP-DED
C-2	Determining Substantial Gainful Activity
C-3	Determining Presumptive Disability
C-4	Completing Disability Evaluation Forms
C-5	Providing CWD Worker Observations
C-6	Assembling and Sending SP-DED Packets
C-7	Communicating with SP-DED and DHS about Changes and Status
C-8	Processing SP-DED Decisions
C-9	Processing Reexaminations, Reevaluations and Redeterminations

C-1: Referring Disability Applications to SSA or SP-DED

1.	Identifies	the impact of the 1990 revisions to the CFR 435.541 regarding the impact of SSA disability decisions on Medi-Cal applications based on disability.
2.	Introduces	optional form MC 017 (Eng/Sp) which gives client an overview of what can be expected when a disability application is filed.
3.	Specifies	situations where client should be referred to SSA.
4.	Lists	situations where client should be referred to SP-DED.

C-2: Determining Substantial Gainful Activity (SGA)

1.	Introduces	the new requirement to determine if a client is working and engaging in Substantial Gainful Activity (SGA) before a case is referred to SP-DED.
2.	Provides	procedures for determining if a client has impairment-related work expenses (IRWE) or subsidy which affect how SGA is determined.
3.	Lists	deductible and non-deductible impairment related work expenses.
4.	Introduces	SGA worksheet (MC 272) for EW use in determining SGA and a Work Activity Report form (MC 273) which provides information about SGA and deductions from gross earnings.
5.	Deletes	references to SGA-Disabled individuals. Disabled individuals who are discontinued from SSI/SSP due to excess income or resources are discussed in C-6.

C-3: Determining Presumptive Disability

1.	Reformats	information released in MEM Letter No. 128 dated February 9, 1994.
2.	Updates	Presumptive Disability categories to be consistent with SSI criteria.
3.	Obsoletes	the need for two medical releases: MC 220A for HIV and MC 220 (12/90), as medical release form MC 220 (7/93) shall be used for any medical condition (including HIV).

4.	Replaces	references to MC 220A medical release form on DHS 7035A/C forms for HIV with MC 220.
5.	Suggests	but does not require CWD to designate an HIV Coordinator for receipt of HIV forms.

C-4: Completing Disability Evaluation Forms

1.	Lists	and updates forms and instructions for their use in the disability evaluation process.
2.	Introduces	MC 017-What You Should Know About Your Medi-Cal Disability Application; MC 222-DED Pending Information Update; MC 272 and MC 273 used for evaluating SGA
3.	Revises	MC 220 (12/90)-medical release form; MC 221-Disability Determination and Transmittal; DHS 7035A/C (HIV forms); DHS 7045-Worker Observations-Disability.
4.	Finalizes	procedures on MC 223 (Statement of Facts) sent in draft in All County Welfare Director's Letter 92-43 dated July 1, 1992.
5.	Reformats	instructions on MC 179 (90 Day Status Letter) recently released in MEM Letter No. 129 on February 17, 1994.

C-5: Providing CWD Worker Observations

1.	Provides	guidelines for providing EW observations, using the MC 221 comments section of the revised DHS 7045.
2.	Emphasizes	importance of EW observations provided to SP-DED.

C-6: Assembling and Sending SP-DED Packets

1.	Discusses	situations where limited and full packets can be sent to SP-DED.
2.	Lists	the information required for full and limited packets.
3.	Updates	information on referrals for disabled former SSI/SSP recipients, retroactive Medi-Cal, and Railroad Retirement Board recipients.

4.	Emphasizes	the need to send packet no later than 10 calendar days after Statement of Facts (MC 223) is signed.

C-7: Communicating with SP-DED and DHS About Changes and Status

1.	Emphasizes	the need for CWD to use new MC 222 (DED Pending Information Update Form) when notifying SP-DED about changes in a client's situation and identifies the types of changes to be reported.
2.	Allows	the use of MC 4033 (Update to Disability Liaison Lists) for CWDs to notify DHS of any changes to Medi-Cal Liaison Lists. This was provided in MEM Letter No. 120 dated November 2, 1993.
3.	Specifies	methods for receiving (via a quarterly computer status list) and requesting case status information (via direct contact) from SP-DED. This was provided in MEM Letter No. 121 dated October 26, 1993.
4.	Identifies	situations where CWD can contact DHS about problems or changes needed on disability issues in the MEM.

C-8: Processing SP-DED Decisions

1.	Identifies	disabled, not disabled, and no determination codes used by SP-DED on MC 221s.
2.	Specifies	SP-DED and CWD actions in disabled, not disabled and no determination decisions.
3.	Clarifies	CWD and SP-DED actions in no determination decisions and lists good cause circumstances.

C-9: Processing Reexaminations, Redeterminations and Reevaluations

1.	Specifies	situations where cases require reexaminations, redeterminations, or reevaluations.
2.	Extends	from six to 12 months the time frame for reinstating client after client was discontinued from Medi-Cal for a reason other than disability.
3.	Provides	a chart to highlight the type of and criteria for resubmitted claims, what should be included in the disability packet, and the eligibility status pending SP-DED response.

PART IV: 22D -- DISABILITY EVALUATION DIVISION PROCEDURES

1. Specifies the two components of DED which process federal and Medi-Cal disability claims.

2. Describes the intake and case processing procedures SP-DED follows in handling disability cases.

DISABILITY FORMS UPDATE

FORM*	STATUS	AVAILABLE IN DHS WAREHOUSE	IMPLEMENT	OBSOLETE
MC 017 (10/93)	New	Now	--	
MC 179 (4/93)	Current	Now	--	
MC 220 (12/90)	Current	Now	--	9/30/94
MC 220 (7/93)	Revised	Now	10/1/94	
MC 220A (8/90)	Current	Now	--	9/30/94
MC 221 (12/87)	Current	Now	--	9/30/94
MC 221 (6/93)	Revised	Now	10/1/94	
MC 222 (4/93)	New	Now	--	
MC 223 (10/90)	Current	Now	--	
MC 272 (3/94)	New	8/1/94	10/1/94	
MC 273 (3/94)	New	8/1/94	10/1/94	
MC 4033 (9/93)	Current	Now	--	
DHS 7035 A/C (1/94)	Current	Now	--	9/30/94
DHS 7035 A/C (4/94)	Revised	8/1/94	10/1/94	
DHS 7045 (8/93)	Revised	8/1/94	10/1/94	

*
MC 017 (Separate Eng/Sp) - What You Should Know About Your Medi-Cal Disability Application (optional)
MC 179 (Separate Eng/Sp) - 90 Day Status Letter
MC 220 (Combined Eng/Sp)- Authorization For Release Of Medical Information
MC 220A (Combined Eng/Sp)- Authorization For Release Of Medical Information - AIDS
MC 221 - Disability Determination And Transmittal
MC 222 LA/OAK (Separate) - DED Pending Information Update
MC 223 - Applicant's Supplemental Statement Of Facts For Medi-Cal (Currently Being Revised)
MC 272 - SGA Worksheet (optional)
MC 273 (Separate Eng/Sp) - Work Activity Report
MC 4033 - Update To Disability Liaison Lists
DHS 7035 A/C - Medical Report On Adult/Child With Allegation Of HIV
DHS 7045 - Worker Observations-Disability (optional)

An E-Mail will be sent when the MC 272, MC 273, and DHS 7035A/C are stocked in the DHS Warehouse and ready for ordering.

Implementation of procedures and currently available new/revised forms prior to October 1, 1994 is strongly encouraged. Full implementation by October 1, 1994 is mandatory. To avoid disability packet returns, obsolete forms should not be submitted to SP-DED after that date.

TRAINING ON THE REVISED DISABILITY PROCEDURES

Regional training sessions will be conducted on the revised MEM procedures. Training will be led by MEB staff, SP-DED staff, and a CWD representative to the MABD Committee. It is anticipated that each CWD will send two to three participants to the training session. Training dates (June and July), sites, and agenda are being developed. Additional details will be provided in the near future.

The MC 223 (10/90) is being revised and is expected to be completed before training begins. The regional training on the revised MEM procedures will include information on the revised MC 223.

MABD COMMITTEE MEMBERS

Many thanks go to the members of the MABD Committee who have dedicated many hours of hard work at the monthly meetings, as well as hard work and research outside of the meetings. Members of the Committee have exhibited much dedication in updating the disability procedures to allow better understanding of procedures so that we will be better able to serve our clients.

For their participation, input, and dedication, special thanks go to the members of the Committee, (alphabetically presented) as follows:

Mary Andes, Butte County, Oroville
Barbara Baranski, Orange County, Santa Ana
Elaine Bilot, DHS-MEB, Sacramento
Charles Bos, Alameda County, Oakland
Al Cooper, DHS-County Medical Services Program, Sacramento
Ted Duffield, SP-DED, Oakland
RaNae Dunne, DHS-MEB, Sacramento
Lorraine Graff, SP-DED, Oakland
Cathi Grams, Butte County, Oroville
Kathy Harwell, Stanislaus County, Modesto
Bill Ivey, Los Angeles County, Los Angeles
Karen Kazlauckas, Santa Clara County, San Jose
Lyn Lawson, Yolo County, Woodland
Suzanne Lennan, DED-Central Operations Branch, Sacramento
Ken Loo, San Francisco County, San Francisco
John McDaniel, Yolo County, Woodland
Fran Meister, San Diego County, San Diego
Les Newman, DHS-MEB, Sacramento
Brian Olson, SP-DED, Los Angeles
Pat Takahashi, DHS-MEB, Sacramento
Marie Taketa, DHS-MEB, Sacramento
Pat Walter, San Diego County, San Diego

ACTION REQUIRED

Procedure Revision	Description
Article 4 Pages 4A-1 through 4G-3	Procedures pertaining to processing Disabled-Medically Needy claims

Filing Instructions

Remove Pages	Insert Pages
Procedural Table of Contents Article 4, page PTC-5	Procedural Table of Contents Article 4, page PTC-5
Article 4 Table of Contents Pages 1 through 3	Article 4 Table of Contents Pages 1 through 4
Article 4 4A-1 through 4G-3	None
None	Article 22 Index Pages 1 through 4 Glossary Pages 22A-1 through 22D-3

If there are any questions regarding these procedures, please contact Ms. Pat Takahashi of my staff at (916) 657-1246. Pertinent issues and questions will also be shared in the regional training sessions for general knowledge.

Sincerely,

Original signed by
Ricardo Bustamante for

Frank S. Martucci, Chief
Medi-Cal Eligibility Branch

Article 4 - APPLICATION PROCESS

4H - PROCESSING OF STATUS REPORTS

4I - DILIGENT SEARCH PROCEDURES

4J - PROMPTNESS REQUIREMENT

4K - PROCESSING MEDICALLY INDIGENT ADULTS (MIAs) APPLICANT S

4L - RSDI/UI/DI REPORTS

4M - VERIFICATION OF UNCONDITIONALLY AVAILABLE INCOME

4N - TIMELY REPORTING BY PUBLIC GUARDIANS/CONSER' ATORS OR BENEFICIARY REPRESENTATIVES

4O - ONE MONTH EXTENDED ELIGIBILITY (EDWARDS V MEYERS)

4P - CHILD HEALTH AND DISABILITY PREVENTION (CHDP) PROGRA 1

4Q - PROCEDURES FOR LONG-TERM CARE (LTC) ADMISSIONS AND DISCHARGES FOR SSI/SSP AND MEDI-CAL RECIPIENTS

4S - INSTRUCTIONS FOR THE MC 210 AND SUPPLEMENTS TO THE MC 210

Article 22 - DISABILITY DETERMINATION REFERRALS

22A - INTRODUCTION TO THE DISABILITY PROGRAM

1. FEDERAL DISABILITY REQUIREMENTS

   A. Adults
   B. Children
   C. SSA Definitions

2. STATE DISABILITY REQUIREMENTS

3. OTHER DISABILITY PROGRAMS

22B - AGENCIES INVOLVED IN THE DISABILITY EVALUATION PROCESS

1. SOCIAL SECURITY ADMINISTRATION (SSA) AND FEDERAL PROGRAMS-DISABILITY EVALUATION DIVISION (FP-DED)

2. HEALTH CARE FINANCING ADMINISTRATION (HCFA)

3. STATE DEPARTMENT OF HEALTH SERVICES (DHS)

4. STATE PROGRAMS-DED (SP-DED)

5. COUNTY WELFARE DEPARTMENT (CWD)

22C - COUNTY WELFARE DEPARTMENT PROCEDURES

22 C-1 - REFERRING DISABILITY APPLICATIONS TO SSA OR SP-DED

1. BACKGROUND

2. FEDERAL DISABILITY EVALUATION BY SSA

3. STATE DISABILITY EVALUATION BY SP-DED FOR MEDI-CAL

4. WHO SHOULD NOT BE REFERRED TO SP-DED FOR MEDI CAL

22 C-2 - DETERMINING SUBSTANTIAL GAINFUL ACTIVITY

1. BACKGROUND

2. WHEN TO USE THESE PROCEDURES

3. PROCEDURES

   A. SGA Determinations
   B. Impairment-Related Work Expenses
   C. Subsidies
   D. Notice Of Action
   E. Forms

22 C-3 - DETERMINING PRESUMPTIVE DISABILITY

1. BACKGROUND

2. RESPONSIBILITIES OF CWD AND SP-DED

   A. CWD
   B. SP-DED

3. PD CATEGORIES

4. INSTRUCTIONS FOR CWD TO GRANT PD FOR HIV INFECTIONS

   A. Forms
   B. Handling Of Forms
   C. Signature On Form
   D. Client Has A Medical Source
   E. Evaluating The Completed DHS 7035A (Adult) Form
   F. Evaluating The Completed DHS 7035C (Child) Form
   G. Granting PD
   H. Exhibits

22 C-4 - COMPLETING DISABILITY EVALUATION FORMS

1. MC 017/MC 017 (SP)--WHAT YOU SHOULD KNOW ABOUT YOUR MEDI-CAL DISABILITY APPLICATION

2. MC 179/MC 179 (SP)--90 DAY STATUS LETTER

   A. Background
   B. Completing The MC 179
   C. When The MC 179 Is Used
   D. Send Copy of MC 179 To SP-DED

3. MC 220--AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

   A. How The MC 220 Is Used
   B. One MC 220 Per Treating Source
   C. How To Complete The MC 220
   D. Signature Requirements
   E. Authorized Representative (AR) Form In File

4. MC 221--DISABILITY DETERMINATION AND TRANSMITTAL

   A. Use Of Form
   B. How To Complete The MC 221

5. MC 222 LA/MC 222 OAK--DED PENDING INFORMATION UPDATE

   A. Use Of Form
   B. Changes To Report To SP-DED

6. MC 223--APPLICANT'S SUPPLEMENTAL STATEMENT OF FACTS FOR MEDI-CAL (ENGLISH/SPANISH)

   A. Impact Of SSA's Decision
   B. Questions Which Pertain To An SSA Decision
   C. How To Complete The MC 223

7. MC 272--SGA WORKSHEET

8. MC 273--WORK ACTIVITY REPORT (ENGLISH/SPANISH)

9. MC 4033--UPDATE TO DISABILITY LIAISON LISTS

10. DHS 7035A/DHS 7035C--MEDICAL REPORT ON ADULT/CHILD WITH ALLEGATION OF HIV

11. DHS 7045--WORKER OBSERVATIONS-DISABILITY

22 C-5 - PROVIDING CWD WORKER OBSERVATIONS

1. USE OF MC 221 OR DHS 7045

2. USE OF WORKER OBSERVATIONS BY SP-DED

3. GUIDELINES

22 C-6 - ASSEMBLING AND SENDING SP-DED PACKETS

1. PREPARING THE PACKET

   A. Limited Referral
   B. Full Referral
   C. Packet Information For Retroactive Medi-Cal
   D. Referrals For Disabled Former SSI/SSP Recipients
   E. The Railroad Retirement Board (RRB) Packet Referral

2. SENDING THE PACKET

22 C-7 - COMMUNICATING WITH SP-DED AND DHS ABOUT CHANGES AND STATUS

1. NOTIFYING SP-DED ABOUT CHANGES

   A. MC 222 LA/ MC 222 OAK - DED Pending Information Update Form
   B. Type Of Changes To Report To SP-DED
   C. SP-DED Addresses
   D. MC 4033 - Disability Listings Update Form

2. RECEIVING AND REQUESTING CASE STATUS INFORMATION FROM SP-DED

   A. Quarterly Computer Status List
   B. Use Of Disability Listings Update Form (MC 4033)
   C. Questions And Inquiries On Specific Cases

3. CONTACTING THE STATE DEPARTMENT OF HEALTH SERVICES

   A. Problems With Case Status Information
   B. Problems With Disability Referral Policies And Procedures
   C. Consistently Delayed Decisions
   D. Updating The MEM Disability Procedures

22 C-8 - PROCESSING SP-DED DECISIONS

1. DISABLED

   A. SP-DED Action
   B. CWD Action

2. NOT DISABLED

   A. SP-DED Action
   B. CWD Action

An index of major subjects and sections where they can be found is shown below. Acronyms and form numbers are found first, followed by an alphabetical listing of subjects.

INDEX

INDEX

INDEX

INDEX

GLOSSARY OF ACRONYMS

ABD	Aid to the Blind and Disabled
AIDS	Acquired Immunodeficiency Syndrome
ALJ	Administrative Law Judge
AR	Authorized Representative
ARC	AIDS Related Complex
CCR	California Code of Regulations (Title 22)
CFR	Code of Federal Regulations
CWD	County Welfare Department
CWDL	County Welfare Directors Letter
DC	Disabled Child
DEA	Disability Evaluation Analyst
DED	Disability Evaluation Division
DHS	Department of Health Services
DOB	Date of Birth
DOT	Dictionary of Occupational Titles
DSS	Department of Social Services
EW	Eligibility Worker
FP-DED	Federal Programs-Disability Evaluation Division
HCFA	Health Care Financing Administration
HIV	Human Immunodeficiency Virus
IHSS	In-Home Supportive Services
IRCA	Immigration Reform and Control Act
IRWE	Impairment-Related Work Expenses
LASPB	Los Angeles State Programs Bureau
MC	Medi-Cal
MC	Medical Consultant
MCIN	Medi-Cal Information Notice
MEB	Medi-Cal Eligibility Branch
MEM	Medi-Cal Eligibility Manual
NOA	Notice of Action
OBRA	Omnibus Budget Reconciliation Act
OSPB	Oakland State Programs Bureau
PD	Presumptive Disability
RRB	Railroad Retirement Board
RSDI	Retirement, Survivors and Disability Insurance (Title II)
SAWS	Statewide Automated Welfare System
SDI	State Disability Insurance
SGA	Substantial Gainful Activity
SOC	Share of Cost
SP-DED	State Programs-Disability Evaluation Division
SSA	Social Security Administration
SSI/SSP	Supplemental Security Income/State Supplementary Program (Title XVI)
SSN	Social Security Number
VA	Veterans Administration
VR	Vocational Rehabilitation
WC	Workers' Compensation

22A -- INTRODUCTION TO THE DISABILITY PROGRAM

Methods for confirming disability are listed in the California Code of Regulations, Title 22, Section 50167(a)(1), (A) through (B). The following describes disability requirements for federal disability under Social Security and state disability under Medi-Cal.

1. FEDERAL DISABILITY REQUIREMENTS (Title 22, Section 50223)

A. ADULTS

Federal law defines a person 18 years or older as disabled if the Social Security Administration's (SSA's) disability criteria for Title II, Retirement, Survivors and Disability Insurance (RSDI), or Title XVI, Supplemental Security Income (SSI), are met.

Title II (RSDI) Benefits — SSA administers monthly payments to aged, blind and disabled persons who have previously worked and have sufficient work quarters.

Title XVI (SSI) Benefits — SSA administers monthly payments to aged, blind and disabled (ABD) persons whose income and resources are below certain limits.

B. CHILDREN

Children under 18 years old are disabled if they have a medically determinable physical or mental impairment which meets the SSI Disabled Child criteria.

C. SSA DEFINITIONS

Disability — Federal law defines disability as "the inability to engage in any Substantial Gainful Activity (SGA) by reason of any medically determinable physical or mental impairment which can be expected to result in death or has lasted or can be expected to last for a continuous period of not less than 12 months".

Substantial Gainful Activity (SGA) — SGA means work that (a) involves doing significant and productive physical or mental duties; and (b) is done, or intended, for pay or profit.

2. STATE DISABILITY REQUIREMENTS (Title 22, Sections 50203 and 50223)

State law requires that Medi-Cal clients, aged 21 to 64 who allege disability, have their eligibility evaluated under the Aged, Blind, and Disabled-Medically Needy (ABD-MN), Title XIX program. The SSA disability criteria for Title II/Title XVI are used to evaluate disability for ABD-MN.

The disability evaluation process also applies to clients who are eligible and linked to other programs (Aid to Families with Dependent Children-Medically Needy, Medically Indigent Children, etc.), who allege disability and who choose to go through this process.

The ABD-MN program is 50 percent federally funded and allows clients to have greater income deductions which may lower or eliminate their Share of Cost (SOC).

3. OTHER DISABILITY PROGRAMS

Disability established under other programs such as State Disability Insurance (SDI), Veterans' Benefits, Workers' Compensation, etc., **DOES NOT** establish disability for Medi-Cal. Recipients of such benefits who apply for Medi-Cal disability, who meet income and resource requirements, must have their claim sent to SP-DED for a disability decision.

22B -- AGENCIES INVOLVED IN THE DISABILITY EVALUATION PROCESS

The roles of various government agencies involved in the disability evaluation process are provided below.

1. SOCIAL SECURITY ADMINISTRATION (SSA) AND FEDERAL PROGRAMS - DISABILITY EVALUATION DIVISION (FP-DED)

The Social Security Administration (SSA) contracts with the Disability Evaluation Division (DED) of the state Department of Social Services to perform medical determinations of disability. There are two components of DED: Federal Programs (FP) Branches determine disability for SSA's Title II program and Title XVI, the Supplemental Security Income (SSI) program and State Programs (SP) Branches determine disability for Title XIX, Medi-Cal, using SSA's criteria for disability under SSI.

Disability Evaluation Analysts in Federal Programs-DED (FP-DED) are responsible for obtaining medical and vocational documentation, ordering consultative examinations, evaluating medical evidence and work and/or social history, and making a disability determination along with a Medical Consultant.

2. HEALTH CARE FINANCING ADMINISTRATION (HCFA)

HCFA administers the Medicaid program and sets forth the federal regulations for its implementation. HCFA has designated the state Department of Health Services (DHS) to oversee the Medicaid program (Medi-Cal) in California.

3. STATE DEPARTMENT OF HEALTH SERVICES (DHS)

DHS is responsible for implementing federal regulations, developing policies and procedures, and providing guidance to ensure compliance with regulations. DHS contracts with State Programs-DED (SP-DED) to do disability evaluations for those applying for Medi-Cal as a blind or disabled person.

DHS works with county welfare departments (CWDs) to ensure that Medi-Cal applications based on disability are processed timely between SP-DED and CWDs.

4. STATE PROGRAMS-DED (SP-DED)

The State Programs-DED located in Los Angeles and Oakland determine disability for Title XIX, Medi-Cal, using SSA's criteria for disability under SSI. SP-DED does disability evaluations for clients applying at CWD for the Aged, Blind and Disabled-Medically Needy (ABD-MN) program. Disability criteria are the same for federal and state DED staff. Upon completion of the disability evaluation of a blind or disabled client, the CWD is advised of the decision so that the Medi-Cal claim processing may be completed.

5. COUNTY WELFARE DEPARTMENT (CWD)

Whereas SP-DED is responsible for the medical determination of disability, the CWD is responsible for the non-medical portion of determining eligibility for Medi-Cal disability.

The following steps should be followed by CWDs when a Medi-Cal client claims to be disabled or blind, either verbally or in writing, such as in the Statement of Facts (MC 210), Status Report (MC 176S), or a letter:

Document	In case record how disability was evaluated.
Confirm	Disability, using methods listed in Title 22, Section 50167(a)(1), (a) through (c).
Refer	Client to SSA or SP-DED if disability is not confirmed by methods listed in Title 22, Section 50167 (a) (1), (a) through (c).
Review	MC 223 to decide if a prior disability decision was made by SSA. If yes, responsibility for a current evaluation **may** belong to SSA and client may be referred back to SSA. An MC Information Notice 13 and a denial notice of action (NOA), if applicable, must be provided to client to take to SSA.

22C -- COUNTY WELFARE DEPARTMENT PROCEDURES

This section lists the various activities the County Welfare Department (CWD) performs in processing claims for Medi-Cal disability. The major CWD activities are listed in separate sections (22 C-1 to C-9) which provide a more comprehensive discussion and instructions for implementation.

C-1.	***Referring Disability Applications To SSA Or SP-DED***	Specifies circumstances in which disability applications are referred to SSA or accepted by CWD for referral to SP-DED.
C-2.	***Determining Substantial Gainful Activity (SGA)***	Provides criteria and instructions on processing claims when applicants are working and engaging in SGA.
C-3.	***Determining Presumptive Disability (PD)***	Provides criteria and procedures for determining if a client can granted PD. Includes detailed criteria for clients with Human Immunodeficiency Virus (HIV) infection.
C-4.	***Completing Disability Evaluation Forms***	Provides a list of forms used in the disability evaluation process. Includes instructions on the use of the forms.
C-5.	***Providing CWD Worker Observations***	Provides background on the importance of CWD observations and how they can be provided to SP-DED. Includes a form which can be used to provide observations to SP-DED.
C-6.	***Assembling And Sending SP-DED Packets***	Discusses limited and full packet situations, retroactive Medi-Cal requests, prior SSI/SSP recipients, and Railroad Retirement Board disability claims.
C-7.	***Communicating With SP-DED And DHS About Changes And Status***	Provides instructions for notifying SP-DED about changes which occur during claim development and use of status information reports provided by SP-DED. Discusses methods to communicate with DHS.
C-8.	***Processing SP-DED Decisions***	Provides information on allowance, denial and no determination decisions. Includes instructions on CWD actions to be taken upon receipt of SP-DED's decision.
C-9.	***Processing Reexaminations, Redeterminations And Reevaluations***	Provides criteria and instructions on how reexaminations, redeterminations and reevaluations should be processed.

22 C-1 -- REFERRING DISABILITY APPLICATIONS TO SSA OR SP-DED

1. BACKGROUND

The 1990 revisions to CFR 435.541 specify the situations when client must be referred back to the Social Security Administration (SSA) to apply for disability benefits, or be allowed to file a Medi-Cal application based on disability. Therefore, it is very important that CWDs carefully review the MC 223 (Applicant's Supplemental Statement of Facts for Medi-Cal) to determine who has jurisdiction over an application for disability benefits.

NOTE: A chart at the end of this section identifies situations when a client is referred to SSA or SP-DED after SSA has made a decision on a disability claim.

When a Medi-Cal application based on disability is accepted from client, optional form MC 017/MC 017 (Sp) may be given to client. This informational form gives client an overview of what can be expected when a disability application is filed.

2. FEDERAL DISABILITY EVALUATION BY SSA

The following are guidelines for referring client to SSA. SSA refers case to FP-DED for a disability evaluation:

SSA Has Denied Disability Status Within The Previous 60 Days	Client must ask SSA to "reconsider" a previous denial action, as client has 60 days to appeal SSA's decision. CWD will deny the Medi-Cal application. If client has a reconsideration request pending with SSA, CWD will deny the Medi-Cal application.
SSA Has Denied Disability Status More Than 60 days But Within One Year Of Current Date	1. Client must ask SSA to "reopen" the previous evaluation. At its discretion, SSA may or may not "reopen" the claim. CWD will deny the Medi-Cal application. 2. If client's same condition has changed or worsened, CWD must refer client back to SSA. CWD will deny the Medi-Cal application.

3. If SSA denied the disability claim after reopening the previous decision, SSA's decision would be controlling over Medi-Cal. CWD will deny the Medi-Cal application.

SSA Denied Claim More Than One Year Before The Current Date

If client does not allege that the same condition has worsened OR that there is a new condition, client will be asked to file a new application with SSA. CWD will deny the Medi-Cal application.

NOTE: Refer to chart at the end of this section to determine when client is referred to SSA.

3. STATE DISABILITY EVALUATION BY SP-DED FOR MEDI-CAL

Listed below are guidelines for determining who should and should not be referred to SP-DED for a Medi-Cal disability evaluation:

A. Who Should NOT Be Referred To SP-DED

Incapacity Or Pregnancy Verification

Do not refer clients to request verification of incapacity or pregnancy.

Prior SP-DED Decision - Disabled

Do not refer client who has had a decision made within the past 12 months unless the reexamination date has passed, or there is an indication that the medical condition has improved.

Prior SP-DED Decision - Not Disabled

Do not refer client who has had a claim denied within the past 90 days. Client should be advised of the appeal process.

However, if CWD believes that the SP-DED denial is incorrect, the case may be sent back for a reevaluation within 90 days, as discussed in C-9.

Other Factors Causing Ineligibility

Do not refer client who does not meet other eligibility factors, such as state residence or resource limits.

Refusal To Be Evaluated

Do not refer client who refuses to be evaluated, as any client has the right to refuse to be evaluated for a disability.

CWD should discuss the possibility of a disability referral with clients who appear to be disabled but who have not requested a disability evaluation.

Example: Client is confined to a wheelchair, or has difficulty walking, standing or sitting; the individual seems disoriented, or shows extreme emotional distress.

Prior SSA Decision-Not Disabled

Do not refer clients to SP-DED who were denied disability status by SSA:

1. Within 60 days: refer to SSA for a reconsideration.
2. Within 12 months: client alleges same condition worsened; does not allege a new condition; did not ask SSA to reopen claim.
3. More than one year ago: client does not allege the same condition has worsened or that there is a new condition.
4. At any time: when client appealed denial and decision on appealed claim is pending.

B. Who SHOULD BE Referred To SP-DED

No Prior SSA Evaluation

Client's disability has never been evaluated by SSA.

SSA Application Status Is Unknown Or Pending

Client's application for RSDI (Title II) or SSI (Title XVI) is pending or client does not know status of claim.

SSA Application Denied Because of Excess Income/Resources

Client's application for SSI is denied for excess income/resources and client has proof of such, and client meets income/resource requirements for Medi-Cal.

SSA Approved Claim

SSA has set a specific onset date as the start of disability, and client is requesting retroactive Medi-Cal coverage prior to that onset date.

SSA Denied Claim	1. SSA denied claim within 12 months, alleges new condition not considered by SSA, has not reapplied with SSA. 2. SSA denied claim over 12 months ago, same condition worsened, has not reapplied with SSA. 3. SSA denied claim over 12 months ago, has new condition not considered by SSA, has not reapplied with SSA.
SSA Discontinued Claim	SSA discontinued SSI benefits for reasons other than disability and client still has the medical condition which was the basis for the SSI decision.
SSA Refuses To Reopen Claim	SSA, at its discretion, refuses to accept a reopening request, and client returns to apply for Medi-Cal disability.
Railroad Retirement Board (RRB) Disability	RRB determined Occupational Disability only.
Medi-Cal Denied Claim	Client was denied Disabled-MN benefits for failure to cooperate with SP-DED and good cause is established.
Former SSI Recipient, 65 Years Or Older	An evaluation for former blind SSI/SSP recipients may be necessary even if client reached age 65 or has already been determined disabled. Under the Pickle Amendment to the Social Security Act, blind individuals are entitled to a higher SSI/SSP payment level than disabled or aged persons. Indicate "Pickle Person" on the MC 221 under "Type of Referral" or packet may be rejected as unnecessary.
In-Home Supportive Services (IHSS)	An applicant for IHSS who is NOT receiving SSI must have an independent evaluation of disability performed by SP-DED.
Immigration Reform And Control Act (IRCA)	IRCA allows certain undocumented aliens to apply for legalization. Full Medi-Cal benefits may be available for those amnesty aliens who are under age 18, disabled, or over 65.

Omnibus Budget Reconciliation Act (OBRA)	OBRA provides restricted Medi-Cal benefits to aliens regardless of alien status. These clients must meet all eligibility requirements, including linkage.

NOTE: Refer to chart at the end of this section to determine when client is referred to SP-DED.

SSA/SP-DED CLIENT REFERRAL CHART

Items 11 to 11D of the MC 223, Applicant's Supplemental Statement of Facts For Medi-Cal, identify whether client has applied for Social Security or SSI disability benefits in the past two years. Client's responses determine whether a disability claim is referred to SSA or SP-DED. The following chart helps to identify where the claim should be referred.

CLIENT STATUS	SITUATION	QUESTIONS AND ANSWERS	SSA	SP-DED
1. Did Not Apply		Q 11 = No		X
2. Applied	Application Status Unknown or Pending	Q 11 = Yes Q 11A = Unknown/Pending		X
3. Allowed/Denied	Decision On Appeal	Q 11 = Yes Q 11A = On Appeal	X	
4. Allowed	Has SSA award letter proving current receipt of benefits.	Q 11A = Approved	None	None
5. Allowed	Has SSA award letter proving current receipt of benefits. Needs retro Medi-Cal.	Q 11A = Approved		X
6. Denied	Has SSA letter proving denial based on income and/or resources.	Q 11A= Denied		X
7. Denied	Denial within previous 60 days. Did not ask SSA to reconsider the previous denial.	Q 11B = Date within 60 days.	X	
8. Denied	Denial within 12 months. Alleges worsening of same condition. (Provides proof, if condition now meets Presumptive Disability criteria.) Did not ask SSA to reopen previous denial.	Q 11B = Date within 12 months. Q 11C = Yes	X	
9. Denied	Denial within 12 months. Has SSA letter proving SSA refusal to reopen previous denial.	Q 11B = Date within 12 months.		X
10. Denied	Denial within 12 months. Alleges new condition not considered by SSA. Has not reapplied with SSA.	Q 11B = Date within 12 months. Q 11D = Yes		X
11. Denied	Denial within 12 months. Does not allege new condition or worsening of same condition.	Q 11B = Date within 12 months. Q 11C/D= No	X	
12. Denied	Denial over 12 months. Same condition worsened, or has new medical problem not considered by SSA. Has not reapplied or appealed with SSA.	Q 11B = Date over 12 months. Q 11C/D = Yes		X
13. Denied	Denial over 12 months. No worsening of same condition, or has no new medical problems.	Q 11B = Date over 12 months. Q 11C/D = No	X	

4/1/94

22 C-2 -- DETERMINING SUBSTANTIAL GAINFUL ACTIVITY

1. BACKGROUND

Section 435.540 of the Code of Federal Regulations (42 CFR) requires Medi-Cal to use the Supplemental Security Income (SSI) definition of disability to decide if a client is eligible for Medi-Cal disability.

To be considered disabled, SSI requires that an individual be:

"unable to engage in **Substantial Gainful Activity** (SGA), due to a medically determined physical or mental impairment, which is expected to result in death, or which is expected to last for a continuous period of 12 months".

A client who performs SGA is not disabled, even if a severe physical or mental impairment exists.

2. WHEN TO USE THESE PROCEDURES

These procedures will be used when a client:

- files for Medi-Cal disability, states on the MC 223 that he/she is working, and has gross earnings of more than $500 per month, or
- meets the criteria for Presumptive Disability (PD), but earns over $500 per month. PD should NOT be approved until an SGA determination is made.

NOTE: These procedures **do not** apply to clients who are blind or to those who return to work after disability has been approved. If an SGA evaluation was not performed because the client alleged blindness, and SP-DED found that the client was disabled but not blind, an SGA evaluation must be performed before eligibility as a disabled person can be established.

3. PROCEDURES

A. SGA DETERMINATIONS

The EW shall determine if client is performing SGA when client has earned income of over $500 per month. The EW shall:

1. *Obtain*: Client's gross monthly earnings (if irregular, earnings should be averaged). Earnings derived from In-Home Supportive Services are treated as earned income. Vacation or sick pay, if received within six months of ending work, is considered earned income.

2. *Determine*: Whether there are impairment-related work expenses (IRWEs) or subsidies that can reduce earnings below $500. (A discussion of IRWEs and subsidies follows.)

3. *Deny*: Claim if "net countable earnings" are over $500.

4. *Submit*: A full disability packet to SP-DED, including an MC 220, MC 221, and MC 223, only if "net countable earnings" are $500 or less.

5. *Alert*: SP-DED via a DED Pending Information Update Form (MC 222) when a disability packet was sent to SP-DED and client is subsequently found to be engaging in SGA.

Work Activity Report form (MC 273, Exhibit 2) may be provided to client whose earnings are over $500 to help in making SGA determinations.

B. IMPAIRMENT-RELATED WORK EXPENSES

Impairment-related work expenses (IRWEs) are certain expenses which are incurred and paid by an impaired client to enable him/her to work.

1. $500 SGA Determination

IRWEs can be deducted from gross earnings to arrive at "net countable earnings". If "net countable earnings" are over $500, deny the application. For self-employment, IRWEs can be deducted from net income, if not already deducted from gross income as a business expense.

Example: Client earns $750 per month and has $100 worth of IRWEs for special transportation costs to go to work, and for medications needed to control a seizure condition. As "net countable earnings" are $650 per month, client is performing SGA and application is denied.

2. Allowable IRWE Deductions

Deductions are allowed when the following conditions exist:

a. Disabled client needs the item/service in order to work. The need must be verified by the prescribing source (e.g. doctor, Vocational Rehabilitation [VR]). The cost must also be verified.

b. Cost is paid by disabled client and not reimbursed by another source (e.g. Medicare, VR). The cost must be paid in cash, including checks or money orders, and not in kind.

c. Expense is "reasonable". It represents comparable charges for the item/service in the community. Sources such as a medical supplier or VR may be contacted.

Example: Client states he/she needs an attendant to assist in activities to prepare for work. Client has a family member perform the services and is charged $15 per hour. If Personal Care Services provided through In-Home Supportive Services allows a payment of $4.25 per hour, only $4.25 should be allowed as a deduction.

3. Budgeting of IRWE

Payment must be made after client became disabled in order for cost to be deducted. Payment is computed in the following ways:

a. Recurring and Non-Recurring IRWEs

1. Recurring costs, such as monthly payments for a wheelchair: the amount paid monthly is deductible.

2. Non-recurring down payments, or full purchase price paid for an item: a lump sum payment may be prorated over 12 months.

b. Cost Incurred Before or After Work

1. Before work started: Prorate the cost over a 12 month period; deduct only the balance of the 12 months while the client is working.

Example: Client paid $600 in January for an item. Work started in April. Prorate the cost over 12 months. IRWE applies to the balance of the 12 months of employment, or $50 per month for April through December.

2. After work ended: Deduct IRWE from the last month earned income is received.

4. IRWE Categories

DEDUCTIBLE

Attendant Care Services

- Performed in work setting or in process of assisting in preparations for work, the trip to/from work and after work (e.g., bathing, dressing, cooking, eating).
- Services which incidentally benefit the family (e.g., cooking meal for individual also eaten by family).
- Services performed by a family member for a cash fee where the family member suffers an economic loss by reducing or terminating work to perform such services.
- Requires verification of duties, of amount of time spent, that they were paid for in cash, and that payment is made on a regular basis.

Transportation Costs

- Structural or operational modifications to vehicle, needed to drive to work or be driven to work, even if also used for non-work purposes.
- Driver assistance or taxicabs where such special transportation is not generally required by unimpaired individuals in the community.
- Mileage expense limited to travel related to employment.

NON DEDUCTIBLE

Attendant Care Services

- Performed on non-workdays or involving shopping or general homemaking (e.g., cleaning, laundry).
- Services performed for someone in the family other than the beneficiary (e.g., babysitting).
- Services performed by a family member for a cash fee where the family member suffers no economic loss.

Transportation Costs

- Cost of a vehicle whether modified or not.
- Cost of modification to a vehicle not directly related to the impairment or critical to the operation of the vehicle (e.g., paint or decor preferences).
- Cost of travel related to obtaining medical items or services.

DEDUCTIBLE	*NON DEDUCTIBLE*
Medical Devices	*Medical Devices*
• Wheelchairs, hemodialysis equipment, pacemakers, respirators, traction equipment, braces (arm, leg, neck, back).	• Any device not used for a medical purpose.
Work-Related Equipment and Assistants	*Work-Related Equipment and Assistants*
• One-handed typewriters, typing aids (e.g., page-turning devices), electronic visual aids, telecommunications devices for people with hearing impairments and special work tools.	• Any work-related device not paid for by the person with a disability or, in the case of a self-employed individual, equipment previously deducted as a business expense.
• Expenses for a person who serves as a reader for a visually impaired person, expenses for an interpreter for a deaf person, and expenses for a job coach.	
Prosthesis	*Prosthesis*
• Artificial hip and artificial replacement of an arm, leg or other part of the body.	• Any prosthetic device that is primarily for cosmetic purposes.
Residential Modifications	*Residential Modifications*
• Individual Employed Outside Home: Modifications to exterior of house to allow access to street or transportation (e.g., exterior ramps, exterior railings, pathways, etc.).	• Individual Employed Outside Home: Modifications to the house primarily intended to facilitate functioning in the home environment (e.g., enlargement of interior door frames, lowering of kitchen appliances and bathroom facilities, interior railings, stairway chairlift, etc.).
• Individual Self-Employed at Home: Modifications made inside home to accommodate impairment (e.g., enlargement of a doorway leading into an office, etc.).	• Individual Self-Employed at Home: Any modification expenses previously deducted as a business expense in determining SGA.

DEDUCTIBLE	***NON DEDUCTIBLE***
Routine Drugs/Medical Services	*Routine Drugs/Medical Services*
• Regularly prescribed medical treatment or therapy that is necessary to control a disabling condition (even if unsuccessful), such as anti-convulsant drugs or blood level monitoring, radiation treatment or chemotherapy, corrective surgery for spinal disorders, anti-depressant medication, etc. The physician's fee relating to these services is deductible.	• Drugs and/or medical services used for only minor physical or mental Problems (e.g., routine physical exams, allergy treatment, dental exams, optician services, etc.).
Diagnostic Procedures	*Diagnostic Procedures*
• Objective of procedure must be related to the control, treatment or evaluation of a disabling condition (e.g., electroencephalograms. brain scans, etc.).	• Procedures paid for by other sources (e.g., VR, Medicare) or not related to a disabling condition (e.g., allergy testing).
Non-Medical Appliances/Devices	*Non-Medical Appliances/Devices*
• In unusual circumstances, when devices or appliances are essential for the control of disabling condition either at home or in the work setting (e.g., an electric air cleaner for a client with severe respiratory disease); the need is verified by a physician.	• Devices used at home or at the office which are not ordinarily for medical purposes (e.g., portable room heaters, air conditioners, humidifiers, dehumidifiers, etc.) and the client has no verified medical work-related need.
Other Items/Services	*Other Items/Services*
• Medical supplies of an expendable nature (e.g., incontinence pads, elastic stockings, catheters).	• An exercise bicycle or other device used for physical fitness unless verified as necessary by a physician.
• The cost of a guide dog, including food, licenses, an veterinary services.	

C. SUBSIDIES

A subsidy is support an individual receives on the job which could result in more pay than the actual value of the services performed. Subsidies:

1. *May involve*: giving the impaired worker the same pay but more supervision or fewer/simpler tasks than other non-impaired workers.

2. *May result in*: more pay than the actual work is worth. Workers in sheltered workshops or settings are generally subsidized.

3. *Are deducted*: from gross earnings to arrive at "net countable earnings" for SGA eligibility determinations but are not considered an earned income exemption for budget determinations, once a medical decision is made.

4. *Should be verified*: by an employer contact to confirm a subsidy exists and determine the value of the subsidy.

*Example: Employer states that the value of client's work is half the actual earnings. Client earns $800 per month. As half the work is subsidized, $400 is considered the real value of work and client is not engaging in SGA. **NOTE**: $800 is the non-exempt income for CWD use in computing client's budget.*

D. NOTICE OF ACTION

If an application for Medi-Cal based on disability is denied due to performance of SGA, client should be sent a Notice of Action (NOA) informing him/her of the reason for the denial. The NOA may contain the following sample statement:

"The reason why you are not entitled to Medi-Cal based on disability is because you are working and doing substantial gainful activity. This means that your earnings are over $500 a month, which is the earnings limit if you are working and applying as a disabled person."

NOTE: The Title 22 reference section is: 50223

E. FORMS

1. SGA Worksheet, Form MC 272 (Exhibit 1):

May be used to compute client's earnings and IRWE/Subsidy deductions.

a. **Net earnings $500 or less**: process the disability application in the usual manner.

b. **Net earnings more than $500**: deny claim as the client is engaging in SGA.

2. Work Activity Report, Form 273 (Exhibit 2):

   Should be used to determine what client's earnings are and whether IRWE or subsidy applies.

3. DED Pending Information Update, Form MC 222:

   Must be sent if a disability packet is pending at SP-DED, and client is subsequently found to be engaging in SGA.

EXHIBIT 1

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

Name of Disabled Person	Social Security Number

SGA WORKSHEET

(USED WHEN GROSS EARNED INCOME IS OVER $500)

1. **ADD EARNED INCOME**
   - a. Gross average monthly earnings $ _____
   - b. Payment in kind (e.g., room and board) _____
   - c. Other _____
   - **TOTAL GROSS EARNINGS** $ _____
2. **SUBTRACT IMPAIRMENT-RELATED WORK EXPENSES (IRWE)**
   - a. Attendant Care Services $ _____
   - b. Transportation Costs _____
   - c. Medical Devices _____
   - d. Work-Related Equipment and Assistants _____
   - e. Prosthesis _____
   - f. Residential Modifications _____
   - g. Routine Drugs and Routine Medical Services _____
   - h. Diagnostic Procedures _____
   - i. Non-Medical Applications and Devices _____
   - j. Other Items and Services _____
   - **TOTAL IRWE DEDUCTIONS** $ _____
3. **SUBTRACT SUBSIDY DEDUCTION** $ _____
4. **NET COUNTABLE EARNINGS** $ _____

If net countable earnings are greater than $500, applicant is engaging in SGA and claim is denied.

Signature & Title of Interviewer or Reviewer	County Code	Date

MC 272 (3/94)

EXHIBIT 2

STATE OF CALIFORNIA - HEALTH AND WELFARE AGENCY

DEPARTMENT OF HEALTH SERVICES

WORK ACTIVITY REPORT

You may be considered disabled for Medi-Cal if you cannot do any kind of work for which you are suited, and only if you cannot work for at least a year or your condition will result in death.

If your earnings are more than $500 a month, in general you cannot be considered disabled. Work expenses and special work considerations related to your disability may be deducted in figuring whether your earnings meet the $500 earnings limits. For this reason, information about your work activity is needed.

The information you provide about your work activity will be used in making a decision on your claim. Your employer may be contacted to verify the information you provide.

Name of Disabled Person		Social Security Number
1. Employer's Name	Employer's Address	Employer's Telephone No.
Title or Name of Your Job	Rate of Pay	Hours Worked Per Week
2. Employer's Name	Employer's Address	Employer's Telephone No.
Title or Name of Your Job	Rate of Pay	Hours Worked Per Week

1. **GROSS EARNING**

What is your gross monthly pay? (If pay is irregular, you do not need to enter the amount.) Attach your pay stubs.

2. **OTHER PAYMENTS**

Specify other payments you receive, such as tips, free meals, room or utilities. Indicate what you were given and estimate the dollar value and how frequently you receive them.

3. **SPECIAL EMPLOYMENT SITUATIONS**

	Yes	No
After you became ill, did your job duties lessen?	☐	☐
If yes, did you get to keep your same pay?	☐	☐
Are you employed by a friend or relative?	☐	☐
Are you in a special training or rehabilitation program?	☐	☐

4. **JOB REQUIREMENTS**

Are your job duties different from those of other workers with the same job title?

	Yes	No
a. shorter hours	☐	☐
b. different pay scale	☐	☐
c. less or easier duties	☐	☐
d. extra help given	☐	☐
e. lower production	☐	☐
f. lower quality	☐	☐
g. other differences (e.g., frequent absences)	☐	☐

MC 273 (3/94)

5. **EXPLANATION OF JOB REQUIREMENTS**

Describe all "yes" answers in item 4 above.

6. **SPECIAL WORK EXPENSES**

Specify below any special expenses related to your condition which are necessary for you to work. These are things which you paid for and not things that will be paid for by anyone else.

Specify the amount of the expenses. Attach verification of who prescribed the item or service needed and the cost paid. (We are required to verify the need for the item or service with the person who prescribed it.)

Example: Attendant care services, transportation costs, medical devices, work-related equipment, prosthesis, modifications to your home, routine drugs and medical services necessary to control a disabling condition, diagnostic procedures, or similar items or services.

7. Use this additional space to answer any previous questions or to give additional information that you think will be helpful.

8. Please read the following statement. Sign and date the form. Provide address and telephone number.

I have completed this form correctly and truthfully to the best of my knowledge and abilities.

Signature of Applicant or Representative	Date	Telephone No. & Area Code
Mailing Address (Number and Street, Apt. No., P.O. Box, or Rural Route)		
City and State	Zip Code	County

FOR COUNTY USE ONLY

9. Interviewer/Reviewer Check List ("Yes" answers should be explained below.) Check all that apply:

a. Subsidy ☐ Yes ☐ No

b. Impairment-Related Work Expenses ☐ Yes ☐ No

c. Substantial Gainful Activity ☐ Yes ☐ No

EXPLANATION: _____

Signature & Title of Interviewer or Reviewer	County Code	Date

MC 273 (3/94)

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

INFORME DE ACTIVIDAD LABORAL

Es posible que se le considere incapacitado(a) para Medi-Cal, si usted no puede hacer ninguna clase de trabajo para el cual está capacitado, y solamente si usted no puede trabajar durante por lo menos un año o si su condición le ocasionará la muerte.

Si sus ingresos son de mas de $500 dólares al mes, en general a usted no se le puede considerar incapacitado. Los gastos de trabajo y consideraciones especiales de trabajo relacionados a su incapacidad se pueden deducir al calcular si sus ingresos cumplen con los límites de ingresos de $500. Por esta razón, se necesita la información acerca de su actividad laboral.

La información que usted proporcione acerca de su actividad laboral se utilizará al tomar una decisión sobre su reclamo. Es posible que nos comuniquemos con su patrono para comprobar la información que usted proporcione.

Nombre de la persona incapacitada		Numero del Seguro Social
1 Nombre del patrono	Direccion del patrono	No. de teléfono del patrono
Puesto o cargo de su trabajo	Tasa de pago	Horas que trabaja a la semana
2 Nombre del patrono	Direccion del patrono	No. de teléfono del patrono
Puesto o cargo de su trabajo	Tasa de pago	Horas que trabaja a la semana

1 **INGRESOS BRUTOS GANADOS**

¿Cuál es su pago mensual bruto? (Si el pago es irregular, no necesita anotar la cantidad.) Adjunte sus talones de cheques.

2 **OTROS PAGOS**

Especifique otros pagos que usted reciba, tales como propinas, alimentos gratuitos, servicios públicos y municipales de cuarto. Indique lo que se le dio y calcule el valor actual y con qué frecuencia los recibe.

3. **SITUACIONES ESPECIALES DE EMPLEO**	Sí	No
Después de enfermarse, ¿se aminoraron sus obligaciones de trabajo?	☐	☐
Si la respuesta es sí, ¿mantuvo el mismo pago?	☐	☐
¿Es usted empleado(a) de un amigo o pariente?	☐	☐
¿Está usted en un programa especial de capacitación o rehabilitación?	☐	☐

4. **REQUISITOS DE EMPLEO**

¿Son sus obligaciones de empleo diferentes a aquellas de otros trabajadores con el mismo puesto?

		Sí	No
a.	horario más corto	☐	☐
b	escala de pago diferente	☐	☐
c	menos obligaciones o más fáciles	☐	☐
d	se le proporciona ayuda adicional	☐	☐
e	producción más baja	☐	☐
f	calidad más baja	☐	☐
g	otras diferencias (ej.: faltas frecuentes)	☐	☐

MC 273 (SP) (1/94) Page 1 of 2

5. **EXPLICACION DE LOS REQUISITOS DE EMPLEO**

Describa todas las respuestas "afirmativas" en el artículo 4 anterior.

6. **GASTOS ESPECIALES DE TRABAJO**

A continuación, especifique cualesquier gastos especiales relacionados a su condición que son necesarios para usted para trabajar. Estos son cosas por las que usted pagó y no cosas que alguien más pagará.

Especifique la cantidad de gastos. Adjunte comprobantes de quién le recetó el artículo o servicio necesario y el costo pagado. (Se nos exige comprobar la necesidad del artículo o servicio con la persona que lo recetó.)

Ejemplo: Servicios de cuidador, costos de transporte, aparatos médicos, equipo relacionado al trabajo, prótesis, modificaciones a su casa, medicamentos de rutina y servicios médicos necesarios para controlar una condición incapacitante, procedimientos de diagnóstico, o artículos o servicios semejantes.

7. Utilice este espacio adicional para contestar cualquier pregunta previa o para dar información adicional que usted piense que será útil.

8. Por favor, lea la siguiente declaración. Firme y feche la forma. Proporcione la dirección y el número de teléfono.

He completado esta forma correcta y verdaderamente según mi leal conocimiento y habilidades.

Firma del Solicitante o Representante	Fecha	Area y No. de Teléfono
Direccion Postal (Numero y Calle, No. de Apt., Apartado Postal o Ruta Rural)		
Ciudad y Estado	Zona Postal	Condado

SOLO PARA USO DEL CONDADO

9. Interviewer/Reviewer Check List ("Yes" answers should be explained below.) Check all that apply:

a. Subsidy ☐ Yes ☐ No

b. Impairment-Related Work Expenses ☐ Yes ☐ No

c. Substantial Gainful Activity ☐ Yes ☐ No

EXPLANATION:

Signature & Title of Interviewer or Reviewer	County Code	Date

MC 273 (SP) (3/94)

22 C-3 -- DETERMINING PRESUMPTIVE DISABILITY

1. BACKGROUND

The process of Presumptive Disability (PD) allows a temporary granting of Medi-Cal eligibility pending a formal determination by SP-DED, provided that client has a condition listed below that is verified by a physician/medical source, and client is otherwise eligible.

Presumptive Disability is granted as of the month of discovery of the disabling condition. PD is **NOT** allowed for retroactive months.

NOTE: ONLY CLIENTS WHO HAVE CONDITIONS THAT ARE LISTED BELOW CAN BE GRANTED PRESUMPTIVE DISABILITY.

2. RESPONSIBILITIES OF CWD AND SP-DED

A. CWD

1. *Medical Statement Provided*

If a medical statement from client's physician verifies the presence of a condition specified on page C-3.3 **and** client is otherwise eligible, grant PD.

a. Explain to client that PD temporarily grants Medi-Cal eligibility pending the formal disability decision by SP-DED.

b. In Item 10, "County Worker Comments" section of the MC 221, check the "PD approved" box.

c. Notify the client via a Notice of Action (NOA) that approval is based on PD.

2. *If SP-DED Grants PD*

CWD should immediately process case and grant PD.

3. *If SP-DED Denies Claim After a PD Decision*

Send a NOA discontinuing the PD. Client cannot receive continued benefits (aid paid pending) if a State Hearing is not requested timely.

B. SP-DED

1. *CWD Notification*

If CWD did not grant PD and SP-DED determines that the client meets PD criteria, the appropriate CWD liaison will be contacted by phone.

2. *MC 221*

When SP-DED requests that CWD grant PD, it will indicate in Item 16, "Basis For Decision" section of the MC 221: "PD decision phoned to CWD liaison; received by (name of contact) on (date)". This remark will be initialed and dated.

A photocopy of the MC 221 will be mailed to CWD liaison as verification that PD was granted.

3. *Formal Decision Made*

SP-DED will process case as quickly as possible to make a formal determination.

If disability is not established when a formal decision is made, SP-DED will indicate in Item 16, "Basis For Decision" section of MC 221: "Previous PD decision not supported by additional evidence".

3. PD CATEGORIES

Grant PD when client meets any of the following conditions:

NO.	IMPAIRMENT CATEGORIES
1	Amputation of two limbs.
2	Amputation of a leg at the hip.
3	Allegation of total deafness.
4	Allegation of total blindness.
5	Allegation of bed confinement or immobility without a wheelchair, walker, or crutches, due to a longstanding condition--excluding recent accident and recent surgery.
6	Allegation of stroke (cerebral vascular accident) more than 3 months in the past and continued marked difficulty in walking or using a hand or arm.
7	Allegation of cerebral palsy, muscular dystrophy, or muscle atrophy and marked difficulty in walking (e.g., use of braces), speaking or coordination of hands or arms.
8	Allegation of diabetes with amputation of a foot.
9	Allegation of Down Syndrome.
10	Allegation of severe mental deficiency (i.e., mental retardation) made by another individual filing on behalf of a client who is at least 7 years of age. The applicant alleges that the client: (a) 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** (b) 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).
11	A child is age 6 months or younger and the birth certificate or other evidence (e.g., hospital admission summary) shows a weight below 1200 grams (2 pounds 10 ounces) at birth.
12	Human immunodeficiency virus (HIV) infection. (See below for details on granting PD for HIV infection.)

4. INSTRUCTIONS FOR CWD TO GRANT PD FOR HIV INFECTIONS

CWD may grant PD for a client with HIV infection whose medical source confirms, on an HIV form, that client has specific disease manifestations. If client has no medical source, CWD will forward packet to SP-DED in the usual manner without preparing an HIV form or granting PD.

If the required HIV criteria are not present, CWD should not grant PD, but should specify "EXPEDITE" in Item 10, "County Worker Comments" section of MC 221.

A. FORMS

Forms used to verify the presence of the HIV and its disease manifestations are:

1. *DHS 7035A* — "Medical Report on **Adult** with Allegation of HIV Infection".

2. *DHS 7035C* — "Medical Report on **Child** with Allegation of HIV Infection". (Client is considered an adult for the purpose of determining PD on the day of his/her 18th birthday.)

Instructional cover sheets attached to the forms contain instructions to the medical source on how to complete them. Copies of forms may be made available to physicians and others, upon request.

B. HANDLING OF FORMS

1. *Appointment Of District Coordinator* — CWDs may wish to appoint a District Coordinator to receive the returned HIV forms to preserve confidentiality of information.

2. *Form Provided To Medical Source For Completion And Return* — CWD generally mails the blank DHS 7035A/DHS 7035C to the medical source for completion/return to the CWD. It may also be given to client to take to the medical source.

3. *Client Brings Completed Form To CWD* — Client may directly request the medical source to complete the form and may bring it directly to CWD.

4. *Telephone Or Other Direct Contact* — CWD may use telephone or other direct contact to verify presence of the disease manifestations.

   CWD will indicate at signature block "Per telephone conversation of (date) with (medical source)".

C. SIGNATURE ON FORM

1. *Acceptable Signature On Form*

CWD will accept completed forms signed by a medical professional (e.g., physician, nurse, or other member of hospital/clinic staff) who can confirm the diagnosis and severity of the HIV disease manifestations.

2. *Questionable Signature On Form*

If there is a question about the acceptability of the signature, call the medical professional for verification. If the signature cannot be verified, DO NOT GRANT PD. Advise SP-DED of CWD's actions and forward form and packet to SP-DED, if not already sent.

D. CLIENT HAS A MEDICAL SOURCE

CWD will take the following actions:

1. *Authorization For Release Of Medical Information*

a. Complete MC 220 "Authorization for Release of Medical Information", obtain client's signature, and attach the signed MC 220 to the DHS 7035A/DHS 7035C.

b. Check the "Medical Release Information" space of the check-block form "MC 220 attached".

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

2. *Completing Section A Of The DHS 7035A/ DHS 7035C*

Enter medical source's name and include client's name, SSN, and date of birth.

3. *Return Envelope*

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

4. *Mailing The Form*

Mail the DHS 7035A/DHS 7035C with attached MC 220 to medical source for completion/return to CWD. Include the specially marked return envelope.

5. *CWD Actions Pending Return Of The HIV Form*

CWD will not hold disability packet pending receipt of form. Indicate on MC 221 under "County Worker Comments" section that "PD is pending", flag the packet, and forward to SP-DED.

6. *Form Returned To CWD By Client Or Mail*

a. Review form and verify that it is properly signed (physician, nurse, or other member of hospital/clinic staff).

b. Grant PD if the appropriate combination of blocks has been checked or completed (see sections E and F below).

c. Contact SP-DED to determine location of original packet and assigned disability evaluation analyst (DEA).

d. Attach a cover sheet (MC 222) to form indicating: 1) case name; 2) SSN; 3) date original packet was sent; 4) DEA; and 5) status of pending PD case.

7. *Information On Client's Condition Received By Telephone Or Other Direct Contact*

a. Complete appropriate blocks on the DHS 7035A/DHS 7035C.

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

c. Grant PD if applicable. If the packet has already been sent to SP-DED, follow 6c and 6d above.

8. *Medical Evidence Received By CWD Along With Completed Form*

a. Grant PD, if applicable; forward form and evidence to SP-DED.

b. Indicate status of PD decision either on MC 221 or on cover sheet (MC 222).

c. If medical evidence is received after form has been received and evaluated, forward it to SP-DED.

9. *Form Received Via Fax*

a. If quality is poor (e.g., paper darkened by copier), photocopy faxed material (quality of fax deteriorates over time), retain the photocopy, and destroy the original fax.

b. If quality is acceptable, retain original.

10. *Fax Source Is Questionable*

Telephone medical source to verify that the form was faxed by medical source. If unacceptable, do NOT grant PD.

DOCUMENT THE TELEPHONE CONTACT IN THE CASE FILE, advise SP-DED of CWD actions and forward form.

E. EVALUATING THE COMPLETED DHS 7035A (ADULT) FORM

Grant PD if the appropriate blocks have been checked or completed on the DHS 7035A.

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

Criteria in a, b, AND c below must be met:

a. Either block in Section B has been checked,

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*

Criteria in a, b, AND c below must be met:

a. Section B has been checked,

b. Section D (both 1 and 2) has been completed:

- D1 - must indicate the presence of "repeated manifestations of HIV infection".
- D2 - at least one of the criteria shown must be checked, *and*

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

"Manifestations of HIV Infection" means conditions that are listed in Section C but do not meet the findings specified there.

"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 than an average of 3 times a year or once every 4 months but lasts substantially longer than 2 weeks.

Exhibits 2 (desk aid for adults with HIV) and 3 (chart with guidelines for evaluating "repeated manifestations") are provided for assistance in granting PD. If CWD has questions as to whether the manifestations are sufficient to grant PD, CWD should send form to SP-DED for the PD.

F. EVALUATING THE COMPLETED DHS 7035C (CHILD) FORM

Grant PD if the appropriate blocks have been checked or completed on the DHS 7035C.

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

Criteria in a, b, AND c below must be met:

a. Either block in Section B has been checked,

b. Any item has been checked in Section C (item 6 is used only for a child less than 13 years old), *and*

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

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

Criteria in a, b, AND c below must be met:

a. Either block in Section B has been checked,

b. Section D, item 1 *and* 2 (a, b, or c, depending on child's age) have been completed, *and*

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

Exhibit 5 (desk aid for children with HIV) is provided for assistance in granting PD. If CWD

has questions as to whether the manifestations listed are sufficient to grant PD, CWD should send form to SP-DED for the PD.

G. GRANTING PD

1.	*Form Confirms Presence Of HIV, And Required Disease Manifestations*	Grant PD if the medical source confirms that required disease manifestations are present, whether or not the client has Acquired Immunodeficiency Syndrome (AIDS)
2.	*Form Confirms Presence Of HIV, But None Of The Other Conditions Shown On The HIV Form Exist*	DO NOT Grant PD. Process under regular procedures, except that CWD should specify **"EXPEDITE"** in the "County Worker Comments" section of the MC 221.
3.	*Form Indicates HIV Is Suspected, But Not Confirmed*	DO NOT Grant PD if HIV is NOT confirmed by laboratory tests or clinical findings. Process under regular procedures.
4.	*CWD Grants PD And Packet Has Not Been Sent*	In Item 10, "County Worker Comments" section of MC 221, CWD will check "PD Approved" box and notify client via a NOA that approval is based on PD.
5.	*CWD Grants PD And Packet Has Been Sent*	CWD will confirm location of disability packet and analyst, attach a cover sheet (MC 222) to form including case name, SSN, date original packet sent and status of pending case, and forward form/cover sheet to SP-DED.
6.	*CWD Is Unable To Grant PD*	If CWD is unable to grant PD because form has not been appropriately completed, or for any other reason, forward form and packet, if appropriate, to SP-DED. This allows SP-DED to develop case further.

H. EXHIBITS

1.	*DHS 7035A*	Medical Report on Adult with Allegation of Human Immunodeficiency Virus (HIV) Infection
2.	*Desk Aid*	County Desk Aid for Making a PD Finding in Adult Claims

3.	*Chart*	Evaluating Completion of Section D, Item 1 - "Repeated Manifestations of HIV Infection" of Adult Claim
4.	*DHS 7035C*	Medical Report on Child with Allegation of Human Immunodeficiency Virus (HIV) Infection
5.	*Desk Aid*	County Desk Aid for Making a PD Finding in Child Claims

EXHIBIT 1

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

MEDICAL SOURCE INSTRUCTION SHEET FOR COMPLETION OF ATTACHED DHS 7035 A
(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 Health Services medical release (MC 220) 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 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 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 D.1)*:

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

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

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

"Manifestations of HIV infection" may include:

- Any conditions listed in Section C, but without the findings specified there, (e.g., 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).

DHS 7035 A (Overshee0) (4/94)

Continued on reverse →

What We Mean By "Marked" Limitation or Restriction in Functioning *(see Item D.2)*:

- 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 in a nursing home.

- 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.

What We Mean By "Activities of Daily Living" *(see Item D.2)*:

- Activities of daily living include, but are not limited to, such activities as doing household chores, grooming 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 illness or its treatment, is not able to maintain a household or take public transportation on a sustained basis or without assistance (even though he or she is able to perform some self-care activities) would have marked limitation of activities of daily living.

What We Mean By "Social Functioning" *(see Item D.2)*:

- 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 and remission caused by the illness or its treatment, cannot engage in social interaction on a sustained basis (even though he or she is able to communicate with close friends or relatives) would have marked difficulty in maintaining social functioning.

What We Mean By "Completing Tasks in a Timely Manner" *(see Item D.2)*:

- Completing tasks in a timely manner involves the ability to sustain concentration, persistence, or pace to permit 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 unable to sustain concentration or pace adequate to complete simple work-related tasks (even though he or she is able 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 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 applicant's application for Medi-Cal based on disability. While giving us the information on this form is voluntary, failure to provide all or part of the requested information could prevent an accurate or timely decision on the named applicant's application. Although the information you furnish is almost never used for any purpose other than making a determination about the applicant's disability, such information may be disclosed by 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, and local government agencies. Many agencies may use matching programs to find or prove that a person qualifies for benefits paid by the Federal Government. The law allows us to do this even if you do not agree to it.

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

DHS 7035 A(Continued) (4/94)

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 220, "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.

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

A. IDENTIFYING INFORMATION:

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

B. HOW WAS HIV INFECTION DIAGNOSED?

☐ Laboratory testing confirming HIV infection

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

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

BACTERIAL INFECTIONS:

1. ☐ **Mycobacterial infection,** (e.g. caused by M. avium-intracellulare, M. kansasii, or M. tuberculosis), at a site other than the lungs, skin, or cervical or hilar lymph nodes
2. ☐ **Pulmonary Tuberculosis,** resistant to treatment
3. ☐ **Nocardiosis**
4. ☐ **Salmonella Bacteremia,** recurrent nontyphoid
5. ☐ **Syphilis or Neurosyphilis,** (e.g., meningovascular syphilis) resulting in neurologic or other sequelae
6. ☐ **Multiple or Recurrent Bacterial Infection(s),** including pelvic inflammatory disease, requiring hospitalization or intravenous antibiotic treatment three or more times in one year

FUNGAL INFECTIONS:

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

SECTION C (continued)

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 two months

28. ☐ **Granulocytopenia,** with absolute neutrophil counts repeatedly below 1,000 cells/mm^3 and documented recurrent systemic bacterial infections occurring at least three times in the last five months

29. ☐ **Thrombocytopenia,** with platelet counts repeatedly below 40,000/mm^3 with at least 1 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 Manifestations of HIV Infection,** (e.g., peripheral neuropathy), with significant and persistent disorganization of motor function in two extremities resulting in sustained disturbance of gross and dexterous movements, or gait and station

HIV WASTING SYNDROME:

32. ☐ **HIV Wasting Syndrome,** characterized by involuntary weight loss of 10 percent or more of baseline (or other significant involuntary weight loss) and, in the absence of a concurrent illness that could explain the findings, involving: chronic diarrhea with 2 or more loose stools daily lasting for 1 month or longer; or chronic weakness and documented fever greater than 38°C (100.4°F) for the majority of 1 month or longer

DIARRHEA:

33. ☐ **Diarrhea,** lasting for one month or longer, resistant to treatment, and requiring intravenous hydration, intravenous alimentation, or tube feeding

CARDIOMYOPATHY:

34. ☐ **Cardiomyopathy** (chronic heart failure, or cor pulmonale, or other severe cardiac abnormality not responsive to treatment)

NEPHROPATHY:

35. ☐ **Nephropathy,** resulting in chronic renal failure

INFECTIONS RESISTANT TO TREATMENT OR REQUIRING HOSPITALIZATION OR INTRAVENOUS TREATMENT THREE OR MORE TIMES IN ONE YEAR:

36. ☐ **Sepsis**

37. ☐ **Meningitis**

38. ☐ **Pneumonia** (non-PCP)

39. ☐ **Septic Arthritis**

40. ☐ **Endocarditis**

41. ☐ **Sinusitis,** radiographically documented

NOTE: If you have checked any of the items in Section C, proceed to Section E if you have no remarks you wish to make about the patient's condition. Then proceed to Sections F and G and sign and date the form.

If you have not checked any of the items in Section C, please complete Section D. See Part VI of the instruction sheet for definitions of the terms you see in Section D. Proceed to Section E if you have any remarks you wish to make about the patient's condition. Then, proceed to Sections F and G and sign and date the form.

D. OTHER MANIFESTATIONS OF HIV INFECTION:

1. **Repeated Manifestations of HIV infection**, including diseases mentioned in Section C, items 1–41, 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:**

   a. The manifestations your patient has had;
   b. The number of episodes occurring in the same one-year period; and
   c. 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 one-year period. (See attached instructions for the definition of "repeated manifestations.")

   If you need more space, please use Section E:

MANIFESTATIONS	NUMBER OF EPISODES IN THE SAME ONE-YEAR PERIOD	DURATION OF EACH EPISODE
[illegible]	[illegible]	[illegible]

AND

2. **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 INFORMATION (Please Print or Type):

Name

Street Address	City	State	ZIP Code

Telephone Number (include Area Code) ( )

Date

[illegible] correct to the best of

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

➤

FOR OFFICE USE ONLY

DHS 7005 A (4/94)

EXHIBIT 2

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 1 - has been completed showing manifestations of HIV infection that are repeated as shown in Exhibit 3
	Item 2 - 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 3

EVALUATING COMPLETION OF SECTION D; ITEM 1 - "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 met
Substantially more than 3	Less than 2 weeks	Requirement is met
Less than 3	Substantially more than 2 weeks	Requirement is met
Unable to determine	Unable to determine	Refer to DED
*REMINDER: If there is any question as to whether the manifestation listed is a manifestation of HIV, refer to DED		

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

Examples

Manifestation(s)	Episodes	Duration	Requirement Is Met?
Anemia	2	2 months each time	Yes[1]
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 4

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

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

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

I. **PURPOSE OF THIS FORM:**

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

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

II. **WHO MAY COMPLETE THIS FORM:**

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

III. **MEDICAL RELEASE:**

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

IV. **HOW TO COMPLETE THE FORM:**

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

V. **HOW TO RETURN THE FORM TO US:**

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

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

How We Use Section D:

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

Special Terms Used in Section D:

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

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

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

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

DHS 7035 C (Continued) (4/94)

Continued on reverse →

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 applicant's application for Medi-Cal based on disability. While giving us the information on this form is voluntary, failure to provide all or part of the requested information could prevent an accurate or timely decision on the named applicant's application. Although the information you furnish is almost never used for any purpose other than making a determination about the applicant's disability, such information may be disclosed by 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, and local government agencies. Many agencies may use matching programs to find or prove that a person qualifies for benefits paid by the Federal Government. The law allows us to do this even if you do not agree to it.

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

DHS 7555 (Coversheet) (4/94)

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 220, "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.

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

A. IDENTIFYING INFORMATION:

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

B. HOW WAS HIV INFECTION DIAGNOSED?

☐ Laboratory testing confirming HIV infection

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

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

BACTERIAL INFECTIONS:

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

FUNGAL INFECTIONS:

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

DHS 7035 C (4/94) | Page 1 of 4

SECTION C (continued)

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 two months

29. ☐ **Granulocytopenia,** with absolute neutrophil counts repeatedly below 1,000 cells/mm^3 and documented recurrent systemic bacterial infections occurring at least three times in the last five months

30. ☐ **Thrombocytopenia,** with platelet count of 40,000/mm^3 or less despite prescribed therapy, or recurrent upon withdrawal of treatment; or platelet counts repeatedly below 40,000/mm^3 with at least 1 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 Third Percentile** from established growth curve (on standard growth charts) that persists for two months or longer

36. ☐ **Involuntary Weight Loss Greater Than Ten Percent of Baseline** that persists for two months or longer

37. ☐ **Growth Impairment,** with fall or 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 one 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 THREE OR MORE TIMES IN ONE YEAR:

42. ☐ **Sepsis**

43. ☐ **Meningitis**

44. ☐ **Pneumonia** (non-PCP)

45. ☐ **Septic Arthritis**

46. ☐ **Endocarditis**

47. ☐ **Sinusitis,** radiographically documented

[redacted]

D. **OTHER MANIFESTATIONS OF HIV INFECTION:**

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

_____

_____

_____

AND

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

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

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

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

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

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

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

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

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

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

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

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

c. **Age 3 to Attainment of Age 18**—Limitation in at least 2 of the following areas:

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

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

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

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

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

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

Name

Street Address	City	State	ZIP Code

Telephone Number (Include Area Code)	Date
( )	

[redacted]

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

➤

[redacted]

EXHIBIT 5

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 1 - has been completed
		AND
		Birth to attainment of age 1 - One or more of the blocks in **item 2a** has been checked,
		OR
		Age 1 to attainment of age 3 - One or more of the blocks in **item 2b** has been checked,
		OR

	Age 3 to attainment of age 18 - At least two of the blocks in item 2c have been checked
	ALERT: The appropriate item 2a., b., or c. 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

22 C-4 -- COMPLETING DISABILITY EVALUATION FORMS

1. MC 017/MC 017 (SP) -- WHAT YOU SHOULD KNOW ABOUT YOUR MEDI-CAL DISABILITY APPLICATION

This is an optional form which may be given to client who wishes to pursue a Med-Cal application based on disability. This informational form gives client an overview of what can be expected when an application based on disability is filed.

2. MC 179/MC 179 (SP) -- 90 DAY STATUS LETTER

A. BACKGROUND

Section 50177 of Title 22 of the California Code of Regulations requires CWDs to complete the determination of eligibility no later than 90 days from the date the client requests Medi-Cal based on disability or blindness. To ensure timeliness, the Radcliffe and Harris v. Coye, et al (Radcliffe) lawsuit specified that:

- Independent disability determinations be made within the time limit required by law; and
- A status letter be issued to client whose disability determination would not be decided within 90 days.

Form MC 179 was developed for client notification by CWD if a disability packet has not been sent to SP-DED by the 80th day from the date disability or blindness is alleged. It informs client of reason(s) for a delay in the claim processing.

The 80th day is counted from the date specified in Item 5 of the MC 221. For **APPLICANT**, date should be the SAWS 1 date; for **BENEFICIARY**, the date should be the date of the most recent MC 223, Applicant's Supplemental Statement of Facts.

B. COMPLETING THE MC 179

The MC 179 (English and Spanish) was developed for CWD use only. This status letter informs client that there has been a delay in processing the disability-based Medi-Cal claim and the reason(s) why the claim has not been referred to SP-DED. The status letter provides check blocks and blank spaces for completion by CWD.

It informs client that "We are awaiting the following information":

- For you to respond to our request for additional information. (CWDs may use their discretion as to inserting additional information on the blank lines.);

- For you to respond to our request to come into the office;
- For you to contact your eligibility worker RIGHT AWAY because your disability form(s) is not completed correctly; and
- Other. (Specify reason(s) in space provided.)

C. WHEN THE MC 179 IS USED

County MUST issue MC 179 in the following situations:

1. No later than the 80th day from date Medi-Cal based on disability is requested, if disability packet has not been submitted to SP-DED, or
2. At any time prior to the 80th day if CWD knows that the packet will not be sent by the 80th day, or
3. If on the 80th day, CWD has a returned SP-DED referral packet, or
4. If CWD received a letter from SP-DED that the MC 179 was missing when SP-DED received the referral packet on the 86th day or later. Attach copy of MC 179 sent to client to a copy of SP-DED's letter with the comment "see attached" on SP-DED's letter, and send to SP-DED.

D. SEND COPY OF MC 179 TO SP-DED

1. Attach copy of MC 179 to SP-DED disability packet if packet has not been sent by the 80th day, is not expected to be sent by the 80th day, or if on the 80th day or later CWD has a returned disability packet.

   Check box in item 10 of the MC 221 which specifies "(MC 179) 90-Day Status Letter Attached" to inform SP-DED that the letter was sent to client.

2. Attach copy of MC 179 to copy of SP-DED's letter which informed CWD that case was received by SP-DED after the 86th day without a copy of the MC 179 included. Enter comment "see attached" on copy of SP-DED's letter.

3. MC 220 -- AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

A. HOW THE MC 220 IS USED

The MC 220 authorizes the release of medical records, including testing and treatment records, for medical conditions including Human Immunodeficiency Virus (HIV), Acquired Immune Deficiency Syndrome (AIDS), or AIDS-Related Complex (ARC) patients.

B. ONE MC 220 PER TREATING SOURCE

An MC 220 signed by client is required for each treating source (one who has treated client for a significant medical problem), testing facility, or agency listed on the MC 223, except for Social Security. Only one treating source may be designated per signed MC 220. Three extra MC 220s containing only client's signature should be obtained.

C. HOW TO COMPLETE THE MC 220

1. *Do*: Enter client's name, Social Security Number, name of doctor, hospital, or clinic where treatment was received, and hospital or clinic record number.

2. *Do Not*: Enter address of treating source or beginning and ending dates of treatment. They will be completed by SP-DED. However, if request is for alcohol or drug abuse information, form should be completely filled out.

3. *Do Not*: Date form as MC 220s are only good for 90 days from date entered. Forms dated more than 90 days prior to SP-DED's receipt will be returned to CWD.

   Undated forms expedite the disability process as they avoid returned packets due to the 90 day requirement. However, if client refuses to sign form unless a date is entered, client will be allowed to date form.

4. *Do Not*: Alter, cross out, white out, or make changes to MC 220, as these are not acceptable to treating source. Any altered MC 220 will be returned by SP-DED.

5. *Do Not*: Send MC 220s with photocopied signatures, as they are not acceptable to treating source.

6. *Do*: Send three extra MC 220s which contain only client's signature. These are used when additional treating sources are identified during case development.

D. SIGNATURE REQUIREMENTS

The MC 220 may be signed by:

- Client;
- Legal representative of a minor or incompetent client;
- Legal or personal representative of a client physically incapable of signing; or
- Personal representative of an incompetent or deceased client.

When requesting the release of medical information pertaining to minor consent services as specified in Article 19B, the minor (who has attained the age of 12) must sign the release.

Special considerations on handling MC 220s are as follows:

1. Client Has A Guardian Or Conservator

   The MC 220 must include signature of guardian or conservator. Enter relationship to client next to signature (e.g., legal guardian).

2. The Client Is Incompetent Or Physically Incapable of Signing

   If client is incompetent or physically incapable of signing, and does not have a guardian or conservator, MC 220 may be signed by the legal or personal representative who is acting on client's behalf. Enter relationship to client next to signature (e.g., spouse, mother, friend). Specify reason why client cannot sign MC 220 below signature line.

3. The Client Can Only Sign With A Mark

   If client can only sign with a mark (e.g., "X") or other unrecognizable symbol (e.g., non-English character), MC 220 must include:

   - Signature or mark of client;
   - Client's name, written next to the "X" or symbol;
   - Signature of witness. NOTE: Witness signatures with an "X" or other unrecognizable symbol are not acceptable; and
   - Relationship of witness to client.

E. AUTHORIZED REPRESENTATIVE (AR) FORM IN FILE

A signed AR form grants another person authority to accompany, assist and represent client during application for or redetermination of Medi-Cal benefits, but does not permit the AR to sign MC 220s, unless client is incompetent. The AR form must be included in the packet sent to SP-DED to allow contact with the AR.

MC 220s must be signed by client unless client is a minor, has a guardian or conservator, is incompetent or physically incapable of signing the releases.

4. MC 221 -- DISABILITY DETERMINATION AND TRANSMITTAL

A. USE OF FORM

This is the transmittal and determination document shared between CWD and SP-DED. It is used only for new applications or resubmitted cases to SP-DED.

NOTE: If a case is pending in SP-DED, DO NOT use the MC 221 to update SP-DED regarding any changes or to provide new information. Use MC 222 - DED Pending Information Update form instead.

The reverse side of this form provides information on how to complete items 5, 6 and 8.

B. HOW TO COMPLETE THE MC 221

Items 1 to 4, and 7: Provides vital information on the applicant.

Item 2: If a Social Security Number is pending, the word "Pending" should be inserted or an explanation as to why there is no number. If left blank, the packet will be returned to CWD.

Item 5: The month, day and year must be provided. For **APPLICANT**, insert the SAWS 1 date. For **BENEFICIARY** who alleges blindness or disability, the date must reflect date CWD becomes aware that beneficiary is requesting a reclassification to a disabled category (the date will most likely be date on MC 223). This is the beginning date for the 90-day promptness requirement of Section 50177 of Title 22 of the California Code of Regulations.

Item 6: List each separate month for which retroactive coverage is requested (not more than 3 months prior to application date).

Item 8: Check all applicable boxes.

Item 9: Check if applicant is currently in a hospital and identify hospital. If checked, include MC 220 for hospital.

Item 10: Insert information CWD needs to relay to SP-DED. Attach additional sheets or forms, such as the DHS 7045 (Worker Observation form), as needed. If additional sheets or forms are attached, check "See Attached Sheet" box.

NOTE: If MC 179 is attached, check "90 Day Status Letter Attached" box. If Presumptive Disability (PD) was granted, check the "PD Approved" box.

Items 11 and 12: CWD worker information and date sent must be clearly identified.

Items 13 to 20: These will be completed by SP-DED. These inform CWD if case is approved, denied or if no determination was made. The decision codes and reasons for the decision are found in Section 22 C-8 -- Processing SP-DED Decisions.

NOTE: On the bottom of MC 221, there are boxes indicating "Oakland" and "Los Angeles". When an MC 221 is received, SP-DED will send CWD copy of MC 221 with one of the boxes checked to inform CWD where the case is located.

5. MC 222 LA/MC 222 OAK -- DED PENDING INFORMATION UPDATE

A. USE OF FORM

This form is sent to SP-DED when CWD becomes aware of new or changed information affecting a pending case. CWDs who send packets to Los Angeles SP-DED will use MC 222 LA. Other CWDs who send packets to Oakland SP-DED will use MC 222 OAK. Use of this form replaces the updating of SP-DED via an MC 221, which will be used only for new applications and resubmitted cases.

B. CHANGES TO REPORT TO SP-DED

CWDs will report the following changes to SP-DED while a disability case is pending in SP-DED:

1. Change in client's address;
2. Change in client's name, telephone or message number;
3. Denial or discontinuance of client on basis of non medical information (e.g., excess property);
4. Withdrawal of application;
5. Cancellation of Authorization for Release of Information (MC 220) by client;
6. Death of client;
7. Receipt of new medical evidence (attach new medical evidence to MC 222);
8. Availability of interpreter (provide name and phone number);
9. Change in EW; and
10. Any other pertinent information which affects SP-DED's actions on a pending case.

6. MC 223 -- APPLICANT'S SUPPLEMENTAL STATEMENT OF FACTS FOR MEDI-CAL (ENGLISH/SPANISH)

The MC 223 helps SP-DED to obtain a clear and accurate picture of client's disabling condition(s). Client should identify **ALL** pertinent medical, vocational, social and/or third party sources who can provide relevant information regarding his/her condition. Addresses and telephone numbers where the sources can be located **MUST** be provided.

A. IMPACT OF SSA'S DECISION

The 1990 revisions to 42 CFR 435.541 clarify the controlling nature of SSA's disability decisions, when client has made both an SSA disability application and a Medi-Cal application based on disability. These revisions specify when client must be referred back to SSA, or be allowed to file a Medi-Cal application based on disability.

It is extremely important that client inform CWD if there has been an SSA disability decision in the past, or if there is a current SSA disability claim pending.

B. QUESTIONS WHICH PERTAIN TO AN SSA DECISION

Questions 11 through 11D help CWD decide when to deny an application for Medi-Cal based on disability and refer client to SSA, or when to submit a disability packet to SP-DED for an independent disability decision.

C. HOW TO COMPLETE THE MC 223

EWs should assist client in completing form thoroughly, as incomplete forms may result in case delays. Any discrepancy, especially in personal information, should be resolved before sending case to SP-DED.

PART 1 - PERSONAL AND MEDICAL INFORMATION

Items 1 through 2B - Identify basic client information. If client has alias(es), indicate name(s) in Item 1.

Item 3 - Provide telephone number where client can be readily reached.

Item 4 - Complete date of birth: month, day and year.

Item 5 - Specify Social Security Number (SSN). Enter "none" if client is OBRA or IRCA as SSN is not required.

Item 6 - Specify current height and weight.

Items 7 through 10 - Specify if client speaks English; if not, having a translator's name and telephone number is helpful when client needs to be contacted.

Item 11 - Indicate if client applied for Social Security or SSI Disability within past two years.

- If "no", submit disability packet to SP-DED;
- If "yes", determine status of SSA's disability claim.
  - did SSA allow or deny claim, or is status unknown or pending?
  - when did SSA make a decision on the federal disability claim?
  - has client's condition worsened?
  - does client have new medical problems?

NOTE: if client is referred to SSA because SSA's decision is binding and SP-DED has no authority to review the claim, CWD will deny application based on disability and issue denial notice of action MC 239 SD (3/92) and the SSA/State Appeal Right notice, MC Information Notice 13 (3/92).

Item 12 - Indicate what medical condition prevents work activity or limits activities of daily living, including treated and untreated conditions. Attach additional pages, if needed.

Item 13 - Indicate how client's medical problem prevents work activity or limits activities of daily living.

Item 14 - Indicate if client stopped working due to medical problems; if so, enter date client stopped working.

Item 15 - Enter all testing performed. If purpose or name of test is unknown, enter "unknown test" in "other" and give name and address of testing facility and date.

Item 16A through 16C - Enter COMPLETE name(s) and address(es) of all doctors. Include Zip Codes. Include complete addresses of any doctor who is out of state/county. **CURRENT telephone numbers including area codes are essential**. After diligent search, if address could not be obtained, specify "client unable to provide" in address space.

Item 17 - Indicate any hospital or clinic where treatment was received.

Item 18 - List third party sources who know client well. They will be contacted if SP-DED needs to clarify client's ability to function.

Item 19A through 19D - Indicate what client does on a day-to-day basis and what interests and social functioning he/she has. This helps SP-DED determine extent of condition and its effects on client's ability to function, especially in mental or emotional disorders.

Item 19E through 19G - Indicate highest grade completed or year GED test was passed. If client is unable to read or write despite stated educational level, enter "functional illiterate" next to grade level. If client attended special education classes, enter "special education" next to grade level.

Item 20 - Indicate employment within the last 15 years. If work was performed during the past 15 years, complete Part 2 of form.

PART 2 - VOCATIONAL INFORMATION

Items 1 and 2 - Enter client's name and Social Security Number.

Items 6a and 6b - Enter job title and dates worked. Provide job description, as job performed may differ from what is described in the Dictionary of Occupational Titles (DOT) which lists jobs performed in the national economy. If no description is provided by client, SP-DED will use DOT's job description.

If more than two jobs were performed in the last 15 years, give client extra copies of "Part 2 - Vocational Information" to complete.

Highlights Of What To Include In Job Description:

- Types of tools, machines or equipment used;
- Whether writing or supervisory duties were involved;
- Frequency and weight of lifting involved;
- Hours spent sitting, standing and walking;
- Other exertional requirements, such as climbing or bending; and
- Description of alterations made to job functions to accommodate impairments, such as special equipment or changes in duties

7. MC 272 -- SGA WORKSHEET

This worksheet is used when applicant has gross earned income of over $500.

Section I Add gross average earnings. Include in-kind payments received, such as room and board, and any other income, such as tips.

Section II Compute allowable Impairment-Related Work Expenses (IRWE is explained in detail in Article 22 C-1 -- Determining SGA) and deduct from gross earnings.

Section III If applicant's work is subsidized (as specified in Article 22 C-1), indicate what subsidy is worth.

Section IV "Net countable earnings", after deductions, should be $500 or less in order for case to be referred to SP-DED. If above $500, client is performing SGA and ineligible for Disabled-MN.

8. MC 273 -- WORK ACTIVITY REPORT (ENGLISH/SPANISH)

Form is provided to applicant to inform him/her about the $500 SGA limit. It gives applicant the opportunity to provide information leading to IRWE or subsidy deductions.

Items 1 to 8	Applicant completes these items.
Item 9	EW indicates if (a) subsidy or (b) IRWE is applied to gross earned income and if applicant is found to be engaging in (c) SGA. EW indicates in "Explanation" section how a decision of SGA or non-SGA was determined.

9. MC 4033 -- UPDATE TO DISABILITY LIAISON LISTS

CWD completes MC 4033 to notify the state of any updates needed for designated liaisons and mailing lists for either:

- MEDI-CAL LIAISON(S) FOR DISABILITY ISSUES, or
- MEDI-CAL LIAISON(S) FOR QUARTERLY STATUS LISTINGS FOR PENDING AND CLOSED DISABILITY CASES.

Check appropriate listing being changed. Specify items being updated. Complete a separate form for each representative and corresponding information being updated. Print or type the information. Send form to DHS-MEB.

10. DHS 7035A / DHS 7035C -- MEDICAL REPORT ON ADULT/CHILD WITH ALLEGATION OF HIV

DHS 7035A is used for an adult, and DHS 7035C for a child, who alleges HIV, AIDS or ARC. These are completed by a medical source when client alleges having Human Immunodeficiency Virus (HIV) infection, Acquired Immune Deficiency Syndrome (AIDS), or AIDS-Related Complex (ARC). Upon receipt of form, CWD processes case under Presumptive Disability (PD) criteria.

Article 22 C-2 -- Determining Presumptive Disability discusses in detail how this form is used and evaluated.

11. DHS 7045 -- WORKER OBSERVATIONS - DISABILITY

CWD staff should use form to record comments on an individual's physical, mental, and/or emotional problems. If DHS 7045 is not used to record observations, CWD should provide observations in Item 10, "County Worker Comments" section of MC 221. Article 22 C-4 -- Providing CWD Worker Observations provides guidelines in assisting EWs in providing observations to SP-DED.

DHS 7045 may be submitted to SP-DED with the disability packet or at a later date, should EW have additional observations to provide.

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

WHAT YOU SHOULD KNOW ABOUT YOUR MEDI-CAL DISABILITY APPLICATION

SHOULD YOU APPLY FOR MEDI-CAL DISABILITY?

You should apply if you have a physical or mental condition that makes you unable to work for at least 12 months in a row.

Have you applied for and been denied Social Security disability or SSI in the past 12 months? If you have, you must tell your Eligibility Worker.

WHAT HAPPENS AFTER YOU HAVE APPLIED?

Usually, your disability claim will be sent to the Disability Evaluation Division (DED) of the State Department of Social Services. A disability analyst and a medical doctor will evaluate it. **Your Eligibility Worker does not have the authority to decide disability.**

- After the DED office receives your disability claim, they may contact you to get more information. If you get a letter, do what the letter says. Keep the letter and call the analyst named in the letter if you have questions about your disability claim.
- The DED office may contact you to arrange for a special medical exam. If you are asked to go to an exam, the exam is free to you and will be used to decide if you are disabled. Do not miss or cancel the exam.
- If you receive letters or phone calls from your disability analyst, answer right away.
- Tell your doctor(s) they may be contacted and that it will help if they send the requested information quickly.
- It is important that you quickly report any changes, especially in address or telephone number to your county Eligibility Worker. Your worker will send this information to the disability analyst. If you are homeless, be sure to keep in touch with your Eligibility Worker.
- Give your worker the phone number and address of a family member, friend, or other person who your worker can contact if you can't be reached.
- If it is decided that you are disabled, your county Eligibility Worker will contact you to get current information on your financial situation. **IT IS IMPORTANT THAT YOU PROVIDE THIS INFORMATION.**

MC 017 (10/93)

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

LO QUE USTED DEBERIA SABER ACERCA DE SU SOLICITUD PARA MEDI-CAL BASADA EN INCAPACIDAD

¿DEBERIA USTED SOLICITAR MEDI-CAL BASADA EN INCAPACIDAD?

Usted debería solicitarla si tiene alguna condición física o mental que le impide trabajar por lo menos 12 meses seguidos.

¿Ha solicitado, y se le ha negado incapacidad del Seguro Social o SSI, en los últimos 12 meses? Si lo ha hecho, tiene que decírselo a su trabajador(a) de elegibilidad.

¿QUE SUCEDE DESPUES QUE USTED HAYA PRESENTADO LA SOLICITUD?

Normalmente, se enviará su solicitud para incapacidad a la División de Evaluación de Incapacidad (DED) del Departamento de Servicios Sociales del Estado. Un analista de incapacidad y un doctor en medicina la evaluarán. **Su trabajador de elegibilidad no tiene la autoridad de decidir si usted está incapacitado(a).**

- Una vez que la oficina de DED reciba su solicitud para incapacidad, es posible que ellos se comuniquen con usted para obtener más información. Si recibe una carta, haga lo que le dice la carta. Conserve la carta y llame al analista que se menciona en la carta si tiene preguntas con relación a su solicitud para incapacidad.
- La oficina de DED posiblemente se ponga en contacto con usted para hacer arreglos para que se haga un examen médico especial. Si le piden que vaya a que le hagan un examen, el examen no le cuesta a usted, y se usará para decidir si está incapacitado(a). No deje de ir al examen, ni lo cancele.
- Si recibe cartas o llamadas telefónicas de su analista de incapacidad, conteste de inmediato.
- Dígale a su doctor(es) que es posible que se pongan en contacto con él, y dígale que ayudará si envía de inmediato la información que se le pida.
- Es importante que usted reporte de inmediato cualesquier cambios, especialmente de dirección o de número de teléfono a su trabajador de elegibilidad del condado. Su trabajador enviará esta información al analista de incapacidad. Si no tiene hogar, asegúrese de mantenerse en contacto con su trabajador de elegibilidad.
- Dé a su trabajador el número de teléfono y la dirección de algún pariente, amistad, u otra persona con quien se pueda poner en contacto su trabajador, para en caso de que no se le pueda localizar a usted.
- Si se decide que usted está incapacitado, su trabajador de elegibilidad se comunicará con usted para obtener información al corriente sobre su situación económica. **ES IMPORTANTE QUE USTED PROPORCIONE ESTA INFORMACION.**

MC 017 (SP) (10/93) 93 24559

STATE OF CALIFORNIA - HEALTH AND WELFARE AGENCY
MEDI-CAL PROGRAM

DEPARTMENT OF HEALTH SERVICES

(County Address)

Date: _____

Case Name: _____

Case No.: _____

Worker Name: _____

District: _____

This letter is to tell you that all of the information necessary to refer your case to State Programs, Disability Evaluation Division for a disability determination has not been received.

Though federal law requires that eligibility for Medi-Cal based on disability be decided within 90 days, we are not able to do so in your case due to the reason(s) checked below.

We are awaiting the following information:

- ☐ For you to respond to our request for additional information (_____)
- ☐ For you to respond to our request to come into the office
- ☐ For you to contact your eligibility worker RIGHT AWAY because your disability form(s) is not completed correctly
- ☐ Other _____

_____

_____

If you have questions about your Medi-Cal application, call me at ( )_____ between _____ a.m. and _____ p.m.

MC 179 (4/93)

STATE OF CALIFORNIA - HEALTH AND WELFARE AGENCY
MEDI-CAL PROGRAM

DEPARTMENT OF HEALTH SERVICES
(Direccion del Condado)

Fecha: _____

Nombre del Caso: _____

_____

No. del Caso: _____

Nombre del trabajador(a): _____

_____

Distrito: _____

Esta carta es para informarle que no se ha recibido toda la información necesaria para mandar su caso a los Programas del Estado, División de Evaluación de Incapacidad para llevar a cabo una determinación sobre incapacidad.

Aun cuando la ley federal requiere que se decida la elegibilidad para recibir Medi-Cal basada en incapacidad en un plazo de 90 días, no podemos hacerlo en el caso suyo debido a la(s) razón(es) marcada(s) enseguida.

Estamos esperando:

☐ que usted nos proporcione la información adicional que le pedimos
(_____)

☐ que usted venga a nuestra oficina como se lo pedimos

☐ que usted se comunique con su trabajador de elegibilidad DE INMEDIATO porque su(s) forma(s) de incapacidad no está(n) llenada(s) correctamente

☐ Otro _____

_____

_____

Si tiene preguntas acerca de su solicitud para Medi-Cal, llámeme
al ( ) _____ entre las _____ a.m. y las _____ p.m.

MC 179 (SP) (4/80)

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

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION
AUTORIZACION PARA PROPORCIONAR INFORMACION MEDICA

Name of Applicant/*Nombre del Solicitante* _____

Social Security Number/*Numero del Seguro Social* _____

I.D. Number/*Numero de Identificación* _____
(Hospital, Clinic, VA, or WCAB)/*(Hospital, Clinica, 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 médicos 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 el Decreto 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 any alcohol and/or drug abuse treatment, and/or psychiatric records under the same conditions as outlined above, and/or 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). 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 sea 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, permanecerá en vigor con respecto a cualquier acción que se haya ejercitado antes que se retirara la petición. La vigencia de esta petición, no durara 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 expirara automáticamente sin pedirlo por escrito .

Autorizo que los resultados de la prueba para detectar cualesquier tratamientos relacionados con el abuso del alcohol y/o drogas, y/o los expedientes siquiátricos para que sean proporcionados bajo las mismas condiciones que se indican arriba, y/o los examenes de los anticuerpos del virus de inmunodeficiencia humana (VIH) *(HIV - human immunodeficiency virus)*, y cualesquier otros indicadores de la situación de inmunidad y antecedentes médicos e información relacionada con el tratamiento del SIDA (*AIDS*) o del complejo relacionado al SIDA (CRS) *(ARC - AIDS-related complex)*. Entiendo que tal informacion 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/*Direccion*

_____ _____ _____
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 medicos proporcionados al programa estatal de Evaluacion de Incapacidades (Disability Evaluation) forman parte del expediente del solicitante de acuerdo a lo estipulado por el Decreto Federal de Confidencialidad de 1974 que establece que el solicitante puede tener acceso a esos expedientes si asi lo solicita. Una condicion para obtener acceso a los expedientes medicos sera que, al presentarse la solicitud, el solicitante tiene que nombrar a un representante para que los reciba, examine, y los repase con el solicitante. Es recomendable, pero no obligatorio, que el representante sea un medico u otro profesional en el ramo de la salud.

MC 220 English/Spanish (7/93)

STATE OF CALIFORNIA - HEALTH AND WELFARE AGENCY

DEPARTMENT OF HEALTH SERVICES

County Welfare Department Address

Return Copy 4
(Send copies 1, 2, and 3 to DED)
DO NOT MAIL TO APPLICANT

County No. | Aid Code | Case Number

DED ADDRESS

1. Applicant Name (Last, First, Mi)

2. Soc. Sec. No. | 3. Date of Birth | 4. Sex ☐ M ☐ F

*5. Date Applied | *6. List Retro Month(s) Mo Yr / Mo Yr / Mo Yr

7. Mailing Address

Telephone No.: ( )

*8. Type of Referral (check appropriate box(es))

- ☐ Initial Referral
- ☐ Retro-Onset
- ☐ Reevaluation
- ☐ Reexamination
- ☐ Redetermination
- ☐ Resubmitted Packet
- ☐ SGA-Disabled
- ☐ OBRA
- ☐ IRCA
- ☐ Pickle-Blind
- ☐ IHSS
- ☐ SGA IHSS

9. Is applicant in a hospital? ☐ Yes ☐ No

Name of Hospital:

10. County Worker Comment(s) (If More Space Needed, Attach Separate Sheet) ☐ See Attached Sheet

☐ 90 Day Status Letter Attached ☐ Presumptive Disability Approved

11. File Reviewed and Approved for Transmittal — Telephone ( )

Worker No. _____ Worker Name _____ (print name)

12. Date Sent

DED USE ONLY

13. It is determined that the applicant

- ☐ Is Disabled ☐ Is Blind ☐ Continues to be Disabled
- Disability/Blindness Onset Date _____
- Reexam Date _____
- ☐ Was Disabled from _____ to _____
- ☐ Is Not Disabled ☐ Is Not Blind ☐ Ceases to be Disabled

14. No Determination

- ☐ Cooperation Issue ☐ Withdrawal of Application
- ☐ Whereabouts Unknown
- ☐ No Response ☐ Other

Reg-Basis Code

15. Diagnosis

16. Basis For Decision (This is NOT a Certification for IHSS) ☐ See Attached Sheet | Listing

17. Analyst | 18. Date | 19. Physician | 20. Date

DISABILITY DETERMINATION AND TRANSMITTAL

☐ OAKLAND ☐ LOS ANGELES

* SEE BACK OF COPY 4
MC 221 (6/93)

Due to the fact that No. 5, No. 6 and No. 8 are items which are frequently misunderstood, the following explanations are given:

No. 5. Date Applied: For a new Medi-Cal applicant, enter the date that the SAWS 1 was signed. For a continuing case enter the date that the disability was first reported to the county.

No. 6. List Retro Month(s): List all months for which applicant requests coverage during the retroactive period (not more than three months prior to any application date).

No. 8. (Check all boxes which apply)

Initial Referral: Check this box to request first time evaluation for disability or blindness. This is used for all initial referrals.

Reexamination: Check box if a reexam date is due/past due or if an evaluation of a beneficiary's disability is needed to determine if medical improvement has occurred. Attach a copy of the prior MC 221.

SGA Disabled: Substantial gainful activity (SGA). Check box if an applicant was an SSI/SSP disabled recipient, became ineligible for SSI/SSP because of SGA (gainful employment), and still has the medical impairment which was the basis of the SSI/SSP disability determination.

Pickle-Blind: Potentially blind individuals who are discontinued from SSI/SSP for any reason must be screened under the Pickle program (DHS 7020). Blindness evaluations for former SSI/SSP recipients for a determination under the Pickle Amendment to the Social Security Act may be necessary even if the individual has reached age 65 or has already been determined to be disabled. This is because blind individuals are entitled to a higher SSI/SSP payment level than disabled or aged persons.

Retro-Onset: Check box only if the beneficiary was previously determined to be disabled and the case is being resubmitted to evaluate for an earlier onset date. (Onset cannot be granted more than three months prior to application.) Attach a copy of the prior MC 221 to the packet. **For new referrals, DO NOT check this box; simply indicate the requested onset in No. 6.**

Redetermination: Check box if a beneficiary was previously determined to be disabled, was discontinued for a reason other than cessation of disability, AND (1) the last DED determination occurred 12 or more months in the past, OR (2) whose reexamination date is due/past due or unknown. Attach a copy of the prior MC 221.

OBRA: Omnibus Budget Reconciliation Act (OBRA) provides restricted Medi-Cal benefits to aliens regardless of their alien status. This includes aliens who are undocumented, have visitor visas and have I-689, fee receipt or the I-688A, employment authorization card. These aliens must meet all other eligibility requirements, including linkage.

IHSS: In Home Supportive Services (IHSS). Check box if a disability evaluation is needed for an IHSS applicant.

Reevaluation: Check box if the county disagrees with DED's denial and is sending the case back for another review within 90 days of DED's decision. Reason for the disagreement must be explained in No. 10. Attach a copy of the prior MC 221.

Resubmitted Packet: Check box if the original packet was received by DED and subsequently returned to the county for needed information, i.e. Z56 (no determination) or Z55 (county return for packet deficiency, upon resubmitting to DED, county should attach a copy of the SPB 105 letter which DED previously attached to the rejected packet). The county will furnish the needed information and return the packet to DED as a Resubmitted Packet. Attach a copy of the prior MC 221.

IRCA: Immigration Reform and Control Act (IRCA) allows certain undocumented aliens to apply for legalization. Full Medi-Cal benefits may be available for these amnesty aliens who are under age 18, blind, disabled or over age 65.

SGA IHSS: Check box if an applicant's SSI benefits have been discontinued due to SGA and the applicant is in need of IHSS. In these DED evaluations, DED must confirm that the applicant's SSI benefit was discontinued due to SGA and prove that the impairment(s) for which SSI was allowed have not improved.

STATE OF CALIFORNIA - HEALTH AND WELFARE AGENCY

DEPARTMENT OF HEALTH SERVICES

DED PENDING INFORMATION UPDATE

COUNTY WELFARE DEPARTMENT ADDRESS

DED ADDRESS

Los Angeles State Disability Program
P. O. Box 30541, Terminal Annex
Los Angeles, CA 90030-9934

County No.	Aid Code	Case No.
	–	–

Social Security No. on MC221 _____ – –

Applicant's Name (Last, First, MI) _____

Date of Birth _____ – –

THIS FORM MUST BE USED WHEN A DED PACKET IS PENDING AT DED AND CHANGED/ADDITIONAL INFORMATION NEEDS TO BE SUBMITTED TO DED (DO NOT USE MC 221 TO REPORT CHANGES OR TO UPDATE INFORMATION)

Check the appropriate box or boxes and complete the information

1. ☐ CHANGE OF ADDRESS
   New Address: _____
   _____
2. ☐ CHANGE OF TELEPHONE NO.
   New Telephone No.: ( ) _____
3. ☐ CHANGE OF SOCIAL SECURITY NO.
   Corrected No.: _____ – –
4. ☐ CASE CLOSED
   Date: _____ (Discontinue Evaluation)
5. ☐ CLIENT DECEASED
   Death Certificate Attached ☐ Yes ☐ No
6. ☐ NON ENGLISH SPEAKING
   Language Spoken: _____
   Interpreter Name: _____ Phone No.: ( ) _____
7. ☐ UPDATED MEDICAL RECORDS ATTACHED
8. ☐ CHANGE OF COUNTY WORKER (See Below)
9. ☐ OTHER _____
   _____
   _____
   _____

Worker Name: (Please Print)	Worker Number:
Date:	Telephone Number: ( )

MC 222 LA (4/93)

STATE OF CALIFORNIA - HEALTH AND WELFARE AGENCY

DEPARTMENT OF HEALTH SERVICES

DED PENDING INFORMATION UPDATE

COUNTY WELFARE DEPARTMENT ADDRESS

DED ADDRESS

Oakland State Disability Program
P. O. Box 23645
Oakland, CA 94623-0645

County No.	Aid Code	Case No.
	– –	

Social Security No. on MC221 _____ – –

Applicant's Name (Last, First, MI) _____

Date of Birth _____ – –

THIS FORM MUST BE USED WHEN A DED PACKET IS PENDING AT DED AND CHANGED/ADDITIONAL INFORMATION NEEDS TO BE SUBMITTED TO DED (DO NOT USE MC 221 TO REPORT CHANGES OR TO UPDATE INFORMATION)

Check the appropriate box or boxes and complete the information

1. ☐ CHANGE OF ADDRESS
   New Address: _____
   _____
2. ☐ CHANGE OF TELEPHONE NO.
   New Telephone No.: ( )_____
3. ☐ CHANGE OF SOCIAL SECURITY NO.
   Corrected No.: _____ – –
4. ☐ CASE CLOSED
   Date:_____ (Discontinue Evaluation)
5. ☐ CLIENT DECEASED
   Death Certificate Attached ☐ Yes ☐ No
6. ☐ NON ENGLISH SPEAKING
   Language Spoken:_____
   Interpreter Name:_____ Phone No.: ( )_____
7. ☐ UPDATED MEDICAL RECORDS ATTACHED
8. ☐ CHANGE OF COUNTY WORKER (See Below)
9. ☐ OTHER _____
   _____
   _____
   _____

Worker Name: (Please Print)	Worker Number:
Date:	Telephone Number: ( )

MC 222 OAK (4/93)

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

APPLICANT'S SUPPLEMENTAL STATEMENT OF FACTS FOR MEDI-CAL

Send Original to DED

COUNTY USE ONLY		
County	Aid	Case Number

PART 1 – PERSONAL AND MEDICAL INFORMATION

1. First, Middle, and Last Name

2A. Home Address	City	ZIP Code
2B. Mailing Address	City	ZIP Code

3. Phone Number ( )	CHECK IF: ☐ no phone ☐ message phone	4. Date of Birth	5. Social Security Number	6. Height	Weight

7. Do you speak English? YES ☐ NO ☐	8. If NO, what language do you speak?	9. Do you have a translator?

10. Translator's Name:	Translator's Phone Number:	Best time to call translator

11. Have you applied for Social Security or Supplemental Security Income (SSI) disability benefits in the past 2 years? YES ☐ NO ☐

IF YES, PLEASE ANSWER THE FOLLOWING

A. Was your Social Security or SSI application allowed or denied? Allowed ☐ Denied ☐ Unknown/pending ☐

B. Date of most recent decision on your Social Security or SSI application: _____

C. Has your medical problem(s) worsened since your last decision? YES ☐ NO ☐

IF YES, please explain _____

D. Do you have any new medical problem(s) which you did not have when the last decision on your Social Security/SSI application was made? YES ☐ NO ☐

IF YES, what medical problem(s) _____

12. List all medical problems (physical or mental) that keep you from working or limit your daily activities, and give the date that each of these problems first began to bother you.

Type of medical problem:	Beginning Date (month/year)

13. Describe how your medical problem(s) affect your ability to work or limit your activities (such as sitting, standing, walking, lifting, bending, reaching, etc.)

14. Did you have to stop working because of your medical problem(s)? YES ☐ NO ☐

IF YES, what is the date you had to stop working? _____

MC 223 (10/90) Page 1 of 6

15. Have you had any of the following tests in the last 12 months:

Test	Check Appropriate Block or Blocks		If "Yes", Show	
	Yes	No	WHERE DONE: (clinic, lab, hospital, doctor)	WHEN DONE: month-year
Electrocardiogram (EKG)				
Treadmill (exercise heart test)				
Chest X-ray				
Other X-ray (Name the body part here: _____)				
Breathing Tests (PFT)				
Blood Tests				
Other (Specify: _____)				

NOTE: Be sure to include the names and addresses of any offices, clinics, labs, or hospitals noted above in Section 16 or 17 of this form.

16A. IDENTIFY BELOW ALL DOCTORS WHO HAVE SEEN OR TREATED YOU FOR YOUR MEDICAL PROBLEM(S) IN THE PAST 12 MONTHS

If you have not been treated in the past 12 months, check here: ☐

NAME:	ADDRESS number	street	suite
TELEPHONE NUMBER (include area code) ( )	city	state	zip code

HOW OFTEN DO YOU SEE THIS DOCTOR?	DATE FIRST SEEN?	DATE LAST SEEN?

REASONS FOR VISITS (show illness or injury for which you had an examination/treatment)

TYPE OF TREATMENT OR MEDICINES RECEIVED (such as surgery, chemotherapy, radiation, and the medicines you take for your illness or injury, if known. If no treatment or medicines, write "NONE".)

B. IDENTIFY BELOW ANY OTHER doctor you have seen since your illness or injury began:

NAME:	ADDRESS number	street	suite
TELEPHONE NUMBER (include area code) ( )	city	state	zip code

HOW OFTEN DO YOU SEE THIS DOCTOR?	DATE FIRST SEEN?	DATE LAST SEEN?

REASONS FOR VISITS (show illness or injury for which you had an examination/treatment)

TYPE OF TREATMENT OR MEDICINES RECEIVED (such as surgery, chemotherapy, radiation, and the medicines you take for your illness or injury, if known. If no treatment or medicines, write "NONE".)

16C. IDENTIFY BELOW ANY OTHER DOCTOR YOU HAVE SEEN SINCE YOUR ILLNESS OR INJURY BEGAN:

NAME	ADDRESS number / street / suite
TELEPHONE NUMBER (include area code) ( )	city / state / zip code

HOW OFTEN DO YOU SEE THIS DOCTOR?	DATE FIRST SEEN?	DATE LAST SEEN?

REASONS FOR VISITS (show illness or injury for which you had an examination/treatment)

TYPE OF TREATMENT OR MEDICINES RECEIVED (such as surgery, chemotherapy, radiation, and the medicines you take for your illness or injury, if known. If no treatment or medicines, write "NONE".)

NOTE: IF YOU HAVE SEEN OTHER DOCTORS SINCE YOUR ILLNESS OR INJURY BEGAN, LIST THEIR NAMES, ADDRESSES, DATES AND REASONS FOR VISITS ON AN ATTACHED SHEET OF PAPER.

17. Have you been hospitalized or treated at a clinic for your illness or injury? YES ☐ NO ☐
If YES, show the following:

A. Name of hospital or clinic	Address number / street / suite
Patient or clinic number	city / state / zip code

Were you an inpatient (stayed overnight)? YES ☐ NO ☐ If "YES", SHOW DATES →	Dates of Admissions	Dates of Discharges
Were you an outpatient? YES ☐ NO ☐ If "YES", SHOW DATES →	Dates of visits	

Reason for hospitalization or clinic visits:

Type of treatment received:

B. Name of hospital or clinic	Address number / street / suite
Patient or clinic number	city / state / zip code

Were you an inpatient (stayed overnight)? YES ☐ NO ☐ If "YES", SHOW DATES →	Dates of Admissions	Dates of Discharges
Were you an outpatient? YES ☐ NO ☐ If "YES", SHOW DATES →	Dates of visits	

Reason for hospitalization or clinic visits:

Type of treatment received:

18. IS THERE ANYONE ELSE (a friend, relative, social worker, etc.) we may contact for more information about your illness or injury and how it limits your daily activities or keeps you from working?

If so, please list below:

NAME	ADDRESS	PHONE NUMBER	RELATIONSHIP TO YOU

19. Social and Educational Information:

Describe your daily activities in the following areas and state how much you do and how often.

A HOUSEWORK (including cooking, cleaning, shopping, and odd jobs around the house and other similar activities):

_____

_____

_____

B. RECREATION AND HOBBIES (gardening, hiking, sewing, bowling, reading, fishing, musical interests, etc.):

_____

_____

_____

C SOCIAL ACTIVITIES (visits with relatives, friends, neighbors, etc. Include phone contacts as well as personal visits.):

_____

_____

_____

D. MEANS OF TRANSPORTATION (drive car, ride bus, motorcycle, walk, ride with someone else, etc.):

_____

_____

E What is the highest grade you completed in school? _____

F I completed school in 19_____

G. I passed the GED in 19_____

20. ☐ I have NOT worked in the last 15 years. Sign below.

☐ I have worked in the last 15 years. Sign below AND COMPLETE PART 2 OF THIS FORM.

I have completed this form correctly and truthfully to the best of my knowledge and abilities.

_____ SIGNATURE		_____ DATE
_____ AUTHORIZED REPRESENTATIVE (if applicable)	_____ TITLE	_____ TELEPHONE
COMPLETED WITH ASSISTANCE OF: _____ NAME	_____ TITLE OR RELATIONSHIP	_____ TELEPHONE

PART 2 – VOCATIONAL INFORMATION

APPLICANT'S SUPPLEMENTAL STATEMENT OF FACTS FOR MEDI-CAL

*Send Original to DED

1. First, Middle, and Last Name | 2. Social Security Number

6. I have worked in the last 15 years. This is a description of all the jobs I have done for at least 30 days during the last 15 years. I have started with my most recent job. (If you had more than two jobs, complete additional pages of this form.)

a. Job Title _____ Type of Business _____

Dates Worked (Month and Year) From _____ To _____

Hours Per Week _____ Rate of Pay _____ Per _____

DESCRIPTION OF THE JOB

This is what I did and how I did it.

These are the tools, machines, and equipment I used.

I took this long to learn the job _____ days or _____ months

I wrote, completed reports, or performed similar duties. ☐ Yes ☐ No

I had supervisory responsibilities. ☐ Yes ☐ No

PHYSICAL ACTIVITY

	Circle One								
I walked this many hours a day at work:	0	1	2	3	4	5	6	7	8
I stood this many hours a day at work:	0	1	2	3	4	5	6	7	8
I sat this many hours a day at work:	0	1	2	3	4	5	6	7	8

I climbed this much: ☐ never ☐ occasionally ☐ frequently ☐ constantly

I bent over this much: ☐ never ☐ occasionally ☐ frequently ☐ constantly

Heaviest weight I lifted:

☐ 10 lbs. ☐ 50 lbs.

☐ 20 lbs. ☐ Over 100 lbs.

Weight I often lifted/carried:

☐ Up to 10 lbs. ☐ Up to 50 lbs.

☐ Up to 25 lbs. ☐ Over 50 lbs.

Did you have any of your current medical problems when you performed this job? ☐ Yes ☐ No

If yes, name of medical problem(s) _____

If yes, did your employer make special arrangements (such as extra breaks, special equipment, change in job duties, etc.) so you could continue to work? ☐ Yes ☐ No

If yes, describe the special arrangements made _____

PLEASE COMPLETE REVERSE SIDE OF THIS PAGE.

b. Job Title _____ Type of Business _____

Dates Worked (Month and Year) From _____ To _____

Hours Per Week _____ Rate of Pay _____ Per _____

DESCRIPTION OF THE JOB

This is what I did and how I did it

These are the tools, machines, and equipment I used.

I took this long to learn the job _____ **days or** _____ **months**

I wrote, completed reports, or performed similar duties. ☐ **Yes** ☐ **No**

I had supervisory responsibilities. ☐ **Yes** ☐ **No**

PHYSICAL ACTIVITY

	Circle One								
I walked this many hours a day at work:	0	1	2	3	4	5	6	7	8
I stood this many hours a day at work:	0	1	2	3	4	5	6	7	8
I sat this many hours a day at work:	0	1	2	3	4	5	6	7	8

I climbed this much: ☐ never ☐ occasionally ☐ frequently ☐ constantly

I bent over this much: ☐ never ☐ occasionally ☐ frequently ☐ constantly

Heaviest weight I lifted:

☐ 10 lbs. ☐ 50 lbs.

☐ 20 lbs. ☐ Over 100 lbs.

Weight I often lifted/carried:

☐ Up to 10 lbs. ☐ Up to 50 lbs.

☐ Up to 25 lbs. ☐ Over 50 lbs.

Did you have any of your current medical problems when you performed this job? ☐ Yes ☐ No

If yes, name of medical problem(s) _____

If yes, did your employer make special arrangements (such as extra breaks, special equipment, chang[illegible] job duties, etc.) so you could continue to work? ☐ Yes ☐ No

If yes, descri[illegible] _____

CHECK O[illegible] OF THE FOLLOWING:

☐ I have had other jobs in the last 15 years and have completed another page of vocational history.

☐ I have not had any other jobs in the last 15 years.

I have completed this form correctly and truthfully to the best of my knowledge and abilities.

Signature _____ Date _____

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

Name of Disabled Person	Social Security Number

SGA WORKSHEET

(USED WHEN GROSS EARNED INCOME IS OVER $500)

1. **ADD EARNED INCOME**
   - a. Gross average monthly earnings $ _____
   - b. Payment in kind (e.g., room and board) _____
   - c. Other _____
   - **TOTAL GROSS EARNINGS** $ _____
2. **SUBTRACT IMPAIRMENT-RELATED WORK EXPENSES (IRWE)**
   - a. Attendant Care Services $ _____
   - b. Transportation Costs _____
   - c. Medical Devices _____
   - d. Work-Related Equipment and Assistants _____
   - e. Prosthesis _____
   - f. Residential Modifications _____
   - g. Routine Drugs and Routine Medical Services _____
   - h. Diagnostic Procedures _____
   - i. Non-Medical Applications and Devices _____
   - j. Other Items and Services _____
   - **TOTAL IRWE DEDUCTIONS** $ _____
3. **SUBTRACT SUBSIDY DEDUCTION** $ _____
4. **NET COUNTABLE EARNINGS** $ _____

If net countable earnings are greater than $500, applicant is engaging in SGA and claim is denied.

Signature & Title of Interviewer or Reviewer	County Code	Date

MC 272 (3/94)

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

WORK ACTIVITY REPORT

You may be considered disabled for Medi-Cal if you cannot do any kind of work for which you are suited, and only if you cannot work for at least a year or your condition will result in death.

If your earnings are more than $500 a month, in general you cannot be considered disabled. Work expenses and special work considerations related to your disability may be deducted in figuring whether your earnings meet the $500 earnings limits. For this reason, information about your work activity is needed.

The information you provide about your work activity will be used in making a decision on your claim. Your employer may be contacted to verify the information you provide.

Name of Disabled Person		Social Security Number
1. Employer's Name	Employer's Address	Employer's Telephone No.
Title or Name of Your Job	Rate of Pay	Hours Worked Per Week
2. Employer's Name	Employer's Address	Employer's Telephone No.
Title or Name of Your Job	Rate of Pay	Hours Worked Per Week

1 **GROSS EARNING**

What is your gross monthly pay? (If pay is irregular, you do not need to enter the amount.) Attach your pay stubs.

2 **OTHER PAYMENTS**

Specify other payments you receive, such as tips, free meals, room or utilities. Indicate what you were given and estimate the dollar value and how frequently you receive them.

3. **SPECIAL EMPLOYMENT SITUATIONS**

	Yes	No
After you became ill, did your job duties lessen?	☐	☐
If yes, did you get to keep your same pay?	☐	☐
Are you employed by a friend or relative?	☐	☐
Are you in a special training or rehabilitation program?	☐	☐

4. **JOB REQUIREMENTS**

Are your job duties different from those of other workers with the same job title?

		Yes	No
a.	shorter hours	☐	☐
b.	different pay scale	☐	☐
c.	less or easier duties	☐	☐
d.	extra help given	☐	☐
e.	lower production	☐	☐
f.	lower quality	☐	☐
g.	other differences (e.g., frequent absences)	☐	☐

MC 273 (3/94)

5. **EXPLANATION OF JOB REQUIREMENTS**

Describe all "yes" answers in item 4 above.

6. **SPECIAL WORK EXPENSES**

Specify below any special expenses related to your condition which are necessary for you to work. These are things which you paid for and not things that will be paid for by anyone else.

Specify the amount of the expenses. Attach verification of who prescribed the item or service needed and the cost paid. (We are required to verify the need for the item or service with the person who prescribed it.)

Example: Attendant care services, transportation costs, medical devices, work-related equipment, prosthesis, modifications to your home, routine drugs and medical services necessary to control a disabling condition, diagnostic procedures, or similar items or services.

7. Use this additional space to answer any previous questions or to give additional information that you think will be helpful

8. Please read the following statement. Sign and date the form. Provide address and telephone number.

I have completed this form correctly and truthfully to the best of my knowledge and abilities.

Signature of Applicant or Representative	Date	Telephone No. & Area Code
Mailing Address (Number and Street, Apt. No., P.O. Box, or Rural Route)		
City and State	Zip Code	County

FOR COUNTY USE ONLY

9. Interviewer/Reviewer Check List ("Yes" answers should be explained below.) Check all that apply:

a. Subsidy ☐ Yes ☐ No

b. Impairment-Related Work Expenses ☐ Yes ☐ No

c. Substantial Gainful Activity ☐ Yes ☐ No

EXPLANATION: _____

Signature & Title of Interviewer or Reviewer	County Code	Date

MC 273 (3/94)

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

INFORME DE ACTIVIDAD LABORAL

Es posible que se le considere incapacitado(a) para Medi-Cal, si usted no puede hacer ninguna clase de trabajo para el cual está capacitado, y solamente si usted no puede trabajar durante por lo menos un año o si su condición le ocasionara la muerte.

Si sus ingresos son de mas de $500 dólares al mes, en general a usted no se le puede considerar incapacitado. Los gastos de trabajo y consideraciones especiales de trabajo relacionados a su incapacidad se pueden deducir al calcular si sus ingresos cumplen con los límites de ingresos de $500. Por esta razón, se necesita la información acerca de su actividad laboral.

La informacion que usted proporcione acerca de su actividad laboral se utilizará al tomar una decisión sobre su reclamo. Es posible que nos comuniquemos con su patrono para comprobar la información que usted proporcione.

Nombre de la persona incapacitada		Numero del Seguro Social
1. Nombre del patrono	Direccion del patrono	No. de teléfono del patrono
Puesto o cargo de su trabajo	Tasa de pago	Horas que trabaja a la semana
2. Nombre del patrono	Direccion del patrono	No. de teléfono del patrono
Puesto o cargo de su trabajo	Tasa de pago	Horas que trabaja a la semana

1. **INGRESOS BRUTOS GANADOS**

¿Cuál es su pago mensual bruto? (Si el pago es irregular, no necesita anotar la cantidad.) Adjunte sus talones de cheques.

2. **OTROS PAGOS**

Especifique otros pagos que usted reciba, tales como propinas, alimentos gratuitos, servicios públicos y municipales de cuarto. Indique lo que se le dio y calcule el valor actual y con qué frecuencia los recibe.

3. **SITUACIONES ESPECIALES DE EMPLEO**

	Sí	No
Después de enfermarse, ¿se aminoraron sus obligaciones de trabajo?	☐	☐
Si la respuesta es sí, ¿mantuvo el mismo pago?	☐	☐
¿Es usted empleado(a) de un amigo o pariente?	☐	☐
¿Está usted en un programa especial de capacitación o rehabilitación?	☐	☐

4. **REQUISITOS DE EMPLEO**

¿Son sus obligaciones de empleo diferentes a aquellas de otros trabajadores con el mismo puesto?

		Sí	No
a.	horario mas corto	☐	☐
b.	escala de pago diferente	☐	☐
c.	menos obligaciones o más fáciles	☐	☐
d.	se le proporciona ayuda adicional	☐	☐
e.	producción mas baja	☐	☐
f.	calidad más baja	☐	☐
g.	otras diferencias (ej., faltas frecuentes)	☐	☐

MC 273 (SP) (1/94)

5 **EXPLICACION DE LOS REQUISITOS DE EMPLEO**

Describa todas las respuestas "afirmativas" en el articulo 4 anterior.

6. **GASTOS ESPECIALES DE TRABAJO**

A continuación, especifique cualesquier gastos especiales relacionados a su condición que son necesarios para usted para trabajar. Estos son cosas por las que usted pagó y no cosas que alguien más pagará.

Especifique la cantidad de gastos. Adjunte comprobantes de quién le recetó el artículo o servicio necesario y el costo pagado. (Se nos exige comprobar la necesidad del artículo o servicio con la persona que lo recetó.)

Ejemplo: Servicios de cuidador, costos de transporte, aparatos médicos, equipo relacionado al trabajo, prótesis, modificaciones a su casa, medicamentos de rutina y servicios médicos necesarios para controlar una condición incapacitante, procedimientos de diagnóstico, o artículos o servicios semejantes.

7 Utilice este espacio adicional para contestar cualquier pregunta previa o para dar información adicional que usted piense que será útil.

8 Por favor, lea la siguiente declaración. Firme y feche la forma. Proporcione la direccion y el número de teléfono.

He completado esta forma correcta y verdaderamente según mi leal conocimiento y habilidades.

Firma del Solicitante o Representante	Fecha	Area y No. de Teléfono

Direccion Postal (Numero y Calle, No. de Apt., Apartado Postal o Ruta Rural)

Ciudad y Estado	Zona Postal	Condado

SOLO PARA USO DEL CONDADO

9 Interviewer/Reviewer Check List ("Yes" answers should be explained below.) Check all that apply:

a Subsidy ☐ Yes ☐ No

b Impairment-Related Work Expenses ☐ Yes ☐ No

c Substantial Gainful Activity ☐ Yes ☐ No

EXPLANATION:

Signature & Title of Interviewer or Reviewer	County Code	Date

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 (9/93)

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

MEDICAL SOURCE INSTRUCTION SHEET FOR COMPLETION OF ATTACHED DHS 7035 A (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 Health Services medical release (MC 220) 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 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 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 D.1)*:

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

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

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

"Manifestations of HIV Infection" may include:

- Any conditions listed in Section C, but without the findings specified there, (e.g., 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).

DHS 7035 A (Coversheet) (4/94)

Continued on reverse →

What We Mean By "Marked" Limitation or Restriction in Functioning *(see Item D.2)*:

- 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 in a nursing home.
- 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.

What We Mean By "Activities of Daily Living" *(see Item D.2)*:

- Activities of daily living include, but are not limited to, such activities as doing household chores, grooming 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 illness or its treatment, is not able to maintain a household or take public transportation on a sustained basis or without assistance (even though he or she is able to perform some self-care activities) would have marked limitation of activities of daily living.

What We Mean By "Social Functioning" *(see Item D.2)*:

- 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 and remission caused by the illness or its treatment, cannot engage in social interaction on a sustained basis (even though he or she is able to communicate with close friends or relatives) would have marked difficulty in maintaining social functioning.

What We Mean By "Completing Tasks in a Timely Manner" *(see Item D.2)*:

- Completing tasks in a timely manner involves the ability to sustain concentration, persistence, or pace to permit 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 unable to sustain concentration or pace adequate to complete simple work-related tasks (even though he or she is able 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 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 applicant's application for Medi-Cal based on disability. While giving us the information on this form is voluntary, failure to provide all or part of the requested information could prevent an accurate or timely decision on the named applicant's application. Although the information you furnish is almost never used for any purpose other than making a determination about the applicant's disability, such information may be disclosed by 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, and local government agencies. Many agencies may use matching programs to find or prove that a person qualifies for benefits paid by the Federal Government. The law allows us to do this even if you do not agree to it.

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

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 220, "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.

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

A. IDENTIFYING INFORMATION:

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

B. HOW WAS HIV INFECTION DIAGNOSED?

☐ Laboratory testing confirming HIV infection

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

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

BACTERIAL INFECTIONS:

1. ☐ **Mycobacterial Infection,** (e.g. caused by M. avium-intracellulare, M. kansasii, or M. tuberculosis), at a site other than the lungs, skin, or cervical or hilar lymph nodes
2. ☐ **Pulmonary Tuberculosis,** resistant to treatment
3. ☐ **Nocardiosis**
4. ☐ **Salmonella Bacteremia,** recurrent nontyphoid
5. ☐ **Syphilis or Neurosyphilis,** (e.g., meningovascular syphilis) resulting in neurologic or other sequelae
6. ☐ **Multiple or Recurrent Bacterial Infection(s),** including pelvic inflammatory disease, requiring hospitalization or intravenous antibiotic treatment three or more times in one year

FUNGAL INFECTIONS:

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

SECTION C (continued)

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 two months

28. ☐ **Granulocytopenia,** with absolute neutrophil counts repeatedly below 1,000 cells/mm^3 and documented recurrent systemic bacterial infections occurring at least three times in the last five months

29. ☐ **Thrombocytopenia,** with platelet counts repeatedly below 40,000/mm^3 with at least 1 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 Manifestations of HIV Infection,** (e.g., peripheral neuropathy), with significant and persistent disorganization of motor function in two extremities resulting in sustained disturbance of gross and dexterous movements, or gait and station

HIV WASTING SYNDROME:

32. ☐ **HIV Wasting Syndrome,** characterized by involuntary weight loss of 10 percent or more of baseline (or other significant involuntary weight loss) and, in the absence of a concurrent illness that could explain the findings, involving: chronic diarrhea with 2 or more loose stools daily lasting for 1 month or longer; or chronic weakness and documented fever greater than 38°C (100.4°F) for the majority of 1 month or longer

DIARRHEA:

33. ☐ **Diarrhea,** lasting for one month or longer, resistant to treatment, and requiring intravenous hydration, intravenous alimentation, or tube feeding

CARDIOMYOPATHY:

34. ☐ **Cardiomyopathy** (chronic heart failure, or cor pulmonale, or other severe cardiac abnormality not responsive to treatment)

NEPHROPATHY:

35. ☐ **Nephropathy,** resulting in chronic renal failure

INFECTIONS RESISTANT TO TREATMENT OR REQUIRING HOSPITALIZATION OR INTRAVENOUS TREATMENT THREE OR MORE TIMES IN ONE YEAR:

36. ☐ **Sepsis**

37. ☐ **Meningitis**

38. ☐ **Pneumonia** (non-PCP)

39. ☐ **Septic Arthritis**

40. ☐ **Endocarditis**

41. ☐ **Sinusitis,** radiographically documented

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 the patient's condition, then proceed to Sections F and G and sign and date the form.

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

D. OTHER MANIFESTATIONS OF HIV INFECTION:

1. **Repeated Manifestions of HIV Infection,** including diseases mentioned in Section C, Items 1–41, 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:**

   a. The manifestations your patient has had;
   b. The number of episodes occurring in the same one-year period; and
   c. 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 one-year period. (See attached instructions for the definition of "repeated manifestations.")

   If you need more space, please use Section E:

MANIFESTATIONS	NUMBER OF EPISODES IN THE SAME ONE-YEAR PERIOD	DURATION OF EACH EPISODE
EXAMPLE: Diarrhea	3	1 month each

AND

2. **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 INFORMATION (Please Print or Type):

Name			
Street Address	City	State	ZIP Code
Telephone Number (Include Area Code) ( )		Date	

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

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

➤

FOR OFFICIAL USE ONLY

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

DHS 7035 A (4/94)

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

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

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

I. PURPOSE OF THIS FORM:

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

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

II. WHO MAY COMPLETE THIS FORM:

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

III. MEDICAL RELEASE:

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

IV. HOW TO COMPLETE THE FORM:

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

V. HOW TO RETURN THE FORM TO US:

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

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

How We Use Section D:

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

Special Terms Used in Section D:

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

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

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

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

DHS 7035 C (Coversheet) (4/94)

Continued on reverse →

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 applicant's application for Medi-Cal based on disability. While giving us the information on this form is voluntary, failure to provide all or part of the requested information could prevent an accurate or timely decision on the named applicant's application. Although the information you furnish is almost never used for any purpose other than making a determination about the applicant's disability, such information may be disclosed by 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, and local government agencies. Many agencies may use matching programs to find or prove that a person qualifies for benefits paid by the Federal Government. The law allows us to do this even if you do not agree to it.

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

DHS 7035 C(Coversheet) (4/94)

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 220, "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.

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

A. IDENTIFYING INFORMATION:

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

B. HOW WAS HIV INFECTION DIAGNOSED?

☐ Laboratory testing confirming HIV infection

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

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

BACTERIAL INFECTIONS:

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

FUNGAL INFECTIONS:

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

SECTION C (continued)

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 two months

29. ☐ **Granulocytopenia,** with absolute neutrophil counts repeatedly below 1,000 cells/mm^3 and documented recurrent systemic bacterial infections occurring at least three times in the last five months

30. ☐ **Thrombocytopenia,** with platelet count of 40,000/mm^3 or less despite prescribed therapy, or recurrent upon withdrawal of treatment; or platelet counts repeatedly below 40,000/mm^3 with at least 1 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 Third Percentile** from established growth curve (on standard growth charts) that persists for two months or longer

36. ☐ **Involuntary Weight Loss Greater Than Ten Percent of Baseline** that persists for two months or longer

37. ☐ **Growth Impairment,** with fall or 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 one 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 THREE OR MORE TIMES IN ONE YEAR:

42. ☐ **Sepsis**

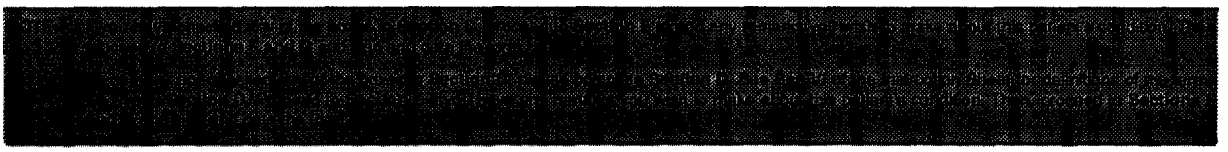
43. ☐ **Meningitis**

44. ☐ **Pneumonia** (non-PCP)

45. ☐ **Septic Arthritis**

46. ☐ **Endocarditis**

47. ☐ **Sinusitis,** radiographically documented



D. OTHER MANIFESTATIONS OF HIV INFECTION:

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

_____

_____

_____

AND

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

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

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

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

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

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

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

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

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

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

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

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

   c. **Age 3 to Attainment of Age 18**—Limitation in at least 2 of the following areas:

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

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

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

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

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

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

Name			
Street Address	City	State	ZIP Code
Telephone Number (Include Area Code) ( )		Date	

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

➤

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

WORKER OBSERVATIONS - DISABILITY

Applicant _____ SSN _____

Check appropriate responses and explain in Remarks where necessary.

1. Did this person appear Pale? _____ Jaundiced (yellow)? _____
2. Was this person wearing a hearing aid? Yes ☐ No ☐
3. Was this person wearing glasses? Yes ☐ No ☐
   a. During the interview, did this person use a magnifying glass? Yes ☐ No ☐
4. Did this person
   a. Use a cane? Yes ☐ No ☐
   b. Use a wheelchair? Yes ☐ No ☐
   c. Use a walker? Yes ☐ No ☐
   d. Walk with a limp? Yes ☐ No ☐
   If Yes, Right_____ Left_____
5. Did this person
   a. Appear to have an injury? Yes ☐ No ☐
   If Yes, explain below.
   b. Appear to be confused/disoriented? Yes ☐ No ☐
   If Yes, explain below.
   c. Have a noticeable breathing difficulty? Yes ☐ No ☐

Remarks: _____

EW: _____ Date: _____

CHS 7045 (8/93)

22 C-5 -- PROVIDING CWD WORKER OBSERVATIONS

Because Eligibility Workers (EWs) have direct contact with clients, observations about a client's condition should be provided to SP-DED. Observations can assist SP-DED by identifying additional conditions or by enhancing information provided by client.

1. USE OF MC 221 OR DHS 7045

EWs may record observations about medical conditions in "CWD Representative Comments" section of MC 221 or on the optional DHS 7045 (Worker Observations - Disability) form. The DHS 7045 may be submitted to SP-DED with disability packet, should observations be extensive and exceed space provided on MC 221, or at a later date, should EW have additional observations to provide.

Unusual behaviors which suggest mental conditions should be noted, as they are frequently not admitted to by client and because they may severely restrict client's ability to work.

EW comments will not be used exclusively to determine if client is or is not disabled.

2. USE OF WORKER OBSERVATIONS BY SP-DED

As SP-DED performs a complete evaluation of a claim, and not only client's alleged condition, it is very important that all conditions be identified.

Example: Client alleged disability on the basis of stomach cancer but did not say she had back and foot problems. She thought the cancer was the disabling problem because it was the only condition being treated. SP-DED determined that the cancer was not disabling. Because the EW noted on the DHS 7045 that client was limping and appeared uncomfortable sitting, SP-DED also explored these observations and found client had back and foot problems. Client was found disabled based on her back and foot problems.

3. GUIDELINES

The following guidelines will assist EWs in providing observations to SP-DED and include some of the more frequently occurring actions or behaviors which may be observed. They are not all-inclusive.

Physical Mobility	Difficulty walking, standing, sitting, or need for another person's assistance in doing these;
	Use of mobility devices, such as wheelchairs, braces, canes, crutches;
	Discomfort while sitting for extended periods of time, or the need to stand periodically to stretch or relax certain muscles;

Difficulty with joints or fingers with stiffness, swelling, shaking, trembling, or the inability to flex fingers resulting in difficulty writing, picking up forms, etc.

Example: Client stood up periodically throughout the interview. She said that she had an inflamed disc in her back that made it hard for her to sit for long periods for time.

Physical Appearance

Height and weight, recent, significant change in weight, unusually thin, overweight, short, malnourished appearance;

Unusual skin conditions such as scaling, peeling, unusual color, scarring, with signs of disfigurement or deformity;

Absence of any extremities, and use of a prosthetic device.

Example: Client had noticeable difficulty walking and sitting. He wore a brace on the right leg and walked with a limp. He braced himself as he sat down. However, he had full use of his upper extremities.

Other Physical Problems

Breathing difficulties, such as frequent coughing or rapid breathing;

Example: Client frequently coughed throughout the interview. When asked if she had a cold, she said, "No, I just cough a lot in the morning".

The appearance that drugs, alcohol, or medication may be affecting client's physical/mental functioning.

Special Senses

Problems with hearing, use of hearing aid, reliance on another to explain what is said, hears only very loud speech;

Problems with seeing, use of glasses, use of magnifying glass to read forms;

Problems with speaking, speech is difficult to understand, slurred or impeded.

Example: Client indicates difficulty reading and hearing. She used a magnifying glass when reading with her glasses on. She said she had an amplifier on her phone, but she was noted not to wear a hearing aid and was able to answer questions without trouble.

Mental And Emotional Status

Does not know his/her name, date and/or time, is disoriented, does not know where he/she is or the reason for the interview;

Has difficulty understanding things, not due to a language barrier, limited attention span and poor memory;

Conversation is repetitive or wandering and responses to questions are inappropriate;

Exhibits signs of deterioration of personal habits, such as poor hygiene or grooming;

Shows signs of emotional distress, such as unusual crying or laughter, or inappropriate outbursts of anger;

Has unusual mannerisms, such as constant twitching of the neck, and inappropriate dress;

Example: Client arrived for appointment at correct time but wrong day. She rambled on about various subjects. She seemed confused and disoriented and her memory was poor. She was vague and evasive when discussing problems.

22 C-6 -- ASSEMBLING AND SENDING SP-DED PACKETS

Disability packets containing forms filled out by client or CWD will initiate a disability referral. SP-DED uses these forms and other information in its disability evaluation process.

1. PREPARING THE PACKET

A. LIMITED REFERRAL

Contains

1. MC 221, Disability Determination and Transmittal, and reason for limited referral shown in "Remarks" section.
2. Copy of prior MC 221, if available.

Submit Only Under These Circumstances

1. When packet is sent within 30 days of SP-DED's decision for a reevaluation and no new treating sources are alleged.
2. When an earlier onset date on an approved case is needed, if within 12 months of application, and no new treating sources are alleged for earlier onset date.

   If SP-DED is unable to establish an earlier onset date with information available, it may return case as a Z56 to request additional information.
3. When client is discontinued from Title XVI due to income or resources and not in receipt of Title II benefits. This includes those who were entitled to IHSS prior to being discontinued from SSI due to earnings.
4. When application is made on behalf of deceased client and appropriate documentation of death is sent. **NOTE**: If death certificate is not available, MC 220s signed by appropriate next-of-kin should be sent.

5. When CWD is unable to verify receipt of SSI benefits, and requests only verification of SSI benefits for IHSS purposes.

Caution Recommended in Limited Packet Referrals

Limited packet cases which do not meet the criteria listed above may be returned by SP-DED to CWD for a full packet.

B. FULL REFERRAL

A full referral packet contains the following forms:

MC 179

90 Day Status Letter

1. For applicant: sent at 80 days after application date (SAWS 1), if packet has not yet been sent to SP-DED for any reason.

2. For beneficiary: sent at 80 days from date MC 223 was signed.

(MC 179 box on MC 221 must be checked, if applicable.)

MC 220

Authorization for Release of Medical Information for each treating source (plus three extra releases with signatures only)

MC 221

Disability Determination and Transmittal

MC 223

Applicant's Supplemental Statement of Facts for Medi-Cal

Appointment of Representative, If Applicable

Allows SP-DED to discuss case with Authorized Representative.

SSA Documents, If Available

Any SSA document regarding benefits or application filed.

Death Certificate, If Applicable

Include copy if client deceased but do not hold packet if unavailable. (If packet already sent to SP-DED, forward with MC 222.)

Other	Any applicable medical documentation previously received, including documentation used for granting PD. If medical records are readily available, they may be submitted with packet. However, do not delay sending packet to obtain medical records.

C. PACKET INFORMATION FOR RETROACTIVE MEDI-CAL

At Initial Application	1. Determine if client requested retroactive Medi-Cal on MC 210; 2. Have client complete MC 210A for specified months; and, 3. Assemble and send **full** packet to SP-DED.
Within 12 Months Of Original Application And Prior To SP-DED Decision	1. Have client complete MC 210A and specify months requested; 2. Complete and send MC 222 to SP-DED and specify retro months requested under "Other" section.
Within 12 Months Of Application And After A Favorable SP-DED Decision	1. Have client complete MC 210A and specify months requested; 2. Complete and send **limited** packet to SP-DED and indicate retro onset on MC 221, along with copy of MC 221 which showed the SP-DED allowance.

D. REFERRALS FOR DISABLED FORMER SSI/SSP RECIPIENTS

Clients under 65 years of age who are discontinued from SSI/SSP for reasons other than cessation of disability (e.g., excess income and resources), and who are not receiving Title II benefits, will need to be referred to SP-DED to determine if disability established by SSA still exists. Disabled former SSI/SSP recipients may also include individuals in long term care (LTC).

These clients fall under Ramos v. Myers court settlement, which entitles client to an extension of Medi-Cal after SSI discontinuance, pending CWD determination of eligibility based on current information from client. Additional information on Ramos v. Myers can be found in Article 5E.

Responsibilities

CWD	1.	Submit a limited packet to SP-DED immediately upon client's application for Medi-Cal. Only the MC 221 is needed. Indicate in the Comments Section that "SSI/SSP discontinued for reasons other than cessation of disability".
	2.	Grant temporary Medi-Cal eligibility pending a formal disability determination by SP-DED.
SP-DED	1.	SP-DED may be able to adopt SSA's disability decision and onset date by querying SSA records. The MC 221 will be sent to CWD indicating approval.
	2.	If SSA's mandatory reexam date (SSA expected the medical condition to improve) has passed or if SSA's disability decision cannot be verified, SP-DED may return a limited packet to CWD as a Z56 case (no determination). A full packet will be requested.

E. THE RAILROAD RETIREMENT BOARD (RRB) PACKET REFERRAL

The RRB, a federal agency responsible for the retirement system for railroad employees, uses SSA's disability criteria for Total and Permanent Disability benefits, but not for its Occupational Disability benefits.

Recipients of Occupational Disability who apply for Medi-Cal disability must have their claim sent to SP-DED for a disability evaluation.

The following steps are taken when an applicant for Medi-Cal based on disability, or when a Medi-Cal beneficiary requests reclassification as a Medi-Cal disabled person:

1. Award Letter Available

When a client presents an RRB disability benefit award letter, benefit change notice, or other verification from RRB, determine what type of RRB disability benefit is awarded.

Total And Permanent Disability	Client **is disabled** for Medi-Cal purposes. Retain copy of RRB's written statement; OR, document disability onset date (or date benefits began), type of RRB disability award, and date of verification for the file.

Occupational Disability

Occupational Disability is based on an inability to perform one's last railroad job and does not consider the ability to perform other work. Submit a **full** packet (MC 220, MC 221, MC 223) to SP-DED.

Type Of Award Not Identified

Client is responsible for obtaining a written statement from RRB which identifies the type of disability benefits awarded. Set a reasonable time frame for compliance. If the client is unable to obtain this verification, submit a full packet to SP-DED and an MC 220 which authorizes SP-DED to obtain copies of the RRB award information.

2. Award Letter Not Available

Occupational Disability

If client states that award is for Occupational Disability, and does not wish to obtain verification from RRB, refer **full** packet to SP-DED and include MC 220 which authorizes SP-DED to obtain copies of RRB award information.

Reclassification Request

If Medi-Cal beneficiary alleges that RRB has determined that he/she is disabled and would like to be reclassified to Medi-Cal disabled category but fails, or refuses without good cause, to cooperate in providing proof about RRB disability benefits, deny Medi-Cal request for reclassification on basis of failure to cooperate.

DO NOT DISCONTINUE MEDI-CAL BENEFITS until/unless all other linkage ceases or another reason for discontinuance exists.

2. SENDING THE PACKET

Check forms and information included in packet to ensure consistency of client's name, Social Security Number and date of birth. Resolve any discrepancy before sending packet.

Send packet to SP-DED **no later than ten calendar days** after date on the Statement of Facts (MC 223) is signed by client, unless there are circumstances beyond CWD's control. When the ten day rule is not met, the situation must be documented in case.

Example: Client fails to give completed information to CWD timely. Case record documents this as the reason for not sending packet within ten days.

22 C-7 -- COMMUNICATING WITH SP-DED AND DHS ABOUT CHANGES AND STATUS

1. NOTIFYING SP-DED ABOUT CHANGES

A. MC 222 LA/ MC 222 OAK - DED PENDING INFORMATION UPDATE FORM

While a disability evaluation is pending, CWD will notify SP-DED about changes in client's situation which affect eligibility or which would enable SP-DED to contact client. MC 222 LA/OAK is used to submit changes and to report information to SP-DED.

CWDs who send packets to Los Angeles SP-DED will use MC 222 LA. Other CWDs who send packets to Oakland SP-DED will use MC 222 OAK.

B. TYPE OF CHANGES TO REPORT TO SP-DED

1. Change in client's address.
2. Change in client's name, telephone or message number.
3. Denial or discontinuance of client on basis of non medical information (e.g., excess property).
4. Withdrawal of application.
5. Cancellation of Authorization for Release of Information (MC 220) by client.
6. Death of client.
7. Receipt of new medical evidence (attach new medical evidence to MC 222).
8. Availability of interpreter (provide name and phone number).
9. Change in EW.
10. Any other pertinent information which affects SP-DED's actions on a pending case.

C. SP-DED ADDRESSES

Disability packets from ***Imperial, Los Angeles, Orange, Riverside, Kern and San Diego Counties*** must be sent to:

Department of Social Services
Disability Evaluation Division
Los Angeles State Programs Bureau
P.O. Box 30541, Terminal Annex
Los Angeles, CA 90030
(213) 965-3316 / 8-730-3316 CALNET

Disability packets from ***all other Counties*** must be sent to:

Department of Social Services
Disability Evaluation Division
Oakland State Programs Bureau
P.O. Box 23645-0645
Oakland, CA 94623
(510) 286-3706 / 8-541-3706 CALNET

D. MC 4033 - DISABILITY LISTINGS UPDATE FORM

CWDs will use MC 4033 to notify the state of any changes to 1) Medi-Cal Liaison List for Disability Issues, or 2) Medi-Cal Liaison List for Quarterly Status Listings for Pending and Closed Disability cases. Check appropriate list and specify items being updated.

These lists are updated on a regular basis and contain names and phone numbers of CWD liaisons which DHS-MEB and SP-DED may need to communicate with CWDs.

2. RECEIVING AND REQUESTING CASE STATUS INFORMATION FROM SP-DED

A. QUARTERLY COMPUTER STATUS LIST

CWDs will receive a quarterly computer status list from SP-DED regarding pending and closed disability cases, along with instructions on its use. If a particular case was forwarded to SP-DED prior to most recent quarterly list and does not appear on list, CWD may contact SP-DED Operations Support Unit Supervisors by telephone or in writing to obtain status information, as follows:

Los Angeles State Programs Bureau

Brian Olson
Operations Support Unit Supervisor
DSS - DED - LASPB
P.O. Box 30541, Terminal Annex
Los Angeles, CA 90030
(213) 965-2061 / 8-730-2061 CALNET

Oakland State Programs Bureau

Lorraine Graff
Operations Support Unit Supervisor
DSS - DED - OSPB
P.O. Box 23645-0645
Oakland, CA 94623
(510) 286-0630 / 8-541-0630 CALNET

B. USE OF DISABILITY LISTINGS UPDATE FORM (MC 4033)

A combined list of Medi-Cal liaisons, district office codes, addresses and telephone numbers will be used to distribute the quarterly status reports. Form MC 4033 (Disability Listings Update) should be used and sent to the Department of Health Services (DHS) to provide updated information to the list. DHS' address is listed on the form.

C. QUESTIONS AND INQUIRIES ON SPECIFIC CASES

In urgent or unusual circumstances, questions and inquiries about specific cases may be directed to the Disability Evaluation Analyst (DEA) assigned to the case, or the Unit Manager. To determine which DEA or Unit is assigned to case, provide client's name and Social Security Number to Masterfiles, at the following numbers:

Los Angeles State Programs Bureau

Masterfiles:
(213) 965-3316 / 8-730-3316 CALNET

Oakland State Programs Bureau

Masterfiles:
(510) 286-1503 / 8-541-1503 CALNET

3. CONTACTING THE STATE DEPARTMENT OF HEALTH SERVICES (DHS)

A. PROBLEMS WITH CASE STATUS INFORMATION

If CWDs experience problems with obtaining case status information which cannot be resolved with SP-DED, appropriate CWD staff should notify the state Department of Health Services, Medi-Cal Eligibility Branch (DHS-MEB).

B. PROBLEMS WITH DISABILITY REFERRAL POLICIES AND PROCEDURES

CWDs should refer disability referral policy and procedure issues to DHS-MEB through their Medi-Cal liaison or disability coordinator.

C. CONSISTENTLY DELAYED DECISIONS

Where disability decisions are consistently delayed (i.e., not completed in a timely manner), CWD should notify DHS-MEB through appropriate channels.

D. UPDATING THE MEM DISABILITY PROCEDURES

DHS-MEB may be informed in writing about corrections, updates or additions to the MEM so that disability procedures may be kept up to date.

22 C-8 -- PROCESSING SP-DED DECISIONS

1. DISABLED

A. SP-DED ACTION

Fully Favorable Allowances — MC 221 disability portion will be completed.

Partially Favorable Allowances — MC 221 Attachment will be included with MC 221 if disability onset date is **AFTER** date of application, or if client was not found disabled during requested period of retroactive coverage.

A personalized denial notice (rationale for decision) will give the reasons for the less than favorable allowance.

ALLOWANCE CODES

A61	Condition meets severity of SSA Listing of Impairments.
A62	Condition equals severity of Listing. (For child, medically/functionally equals level of severity of Listing.)
A63	Medical/vocational considerations. (For child, Individualized Functional Assessment is of comparable severity.)
A64	Medical/vocational considerations--arduous unskilled work profile.
A65	Continuance for reexamination case review.
A98	Reversal by Administrative Law Judge at State Hearing.
A99	Adoption of federal (SSA) allowance.
B61	Statutory blindness.

B. CWD ACTION

Approve — Applicant as disabled, if otherwise eligible, or reclassify beneficiary as Disabled-MN.

Tickle — Case for resubmittal to SP-DED as reexamination case when a reexam date is shown. Reexam dates are set when medical improvement is expected.

Mail

Personalized denial notice (rationale for decision) to client which explains a partially favorable allowance.

NOTE: The MC 221 and MC 221 Attachment are **NEVER** sent to client.

2. NOT DISABLED

A. SP-DED ACTION

MC 221

Block is checked "is not disabled" or "is not blind"; is **NEVER SENT TO CLIENT** for any reason.

MC 221 Attachment

Explains specific reasons for denial and is **NEVER SENT TO CLIENT** for any reason.

Personalized Denial Notice (PDN)

The PDN is an unnumbered, untitled, and unsigned sheet which explains the reason for denial and **can** be mailed to client.

DENIAL CODES

N30/N40*	Condition not severe.
N31/N42*	Capacity for SGA--any past relevant work.
N32/N43*	Capacity for SGA--other than past relevant work.
N34/N45*	Condition prevented SGA for a period of less than 12 months. (For child, condition disabling for a period of less than 12 months.)
N35/N46*	Condition prevented SGA at time of decision but is not expected to prevent SGA for a period of 12 months. (For child, condition disabling at time of decision but not expected to disabling for a period of 12 months.)
N39	Client willfully fails to follow prescribed treatment.
N40/N51*	For child, Individualized Functional Assessment shows conditions not of comparable severity.
N44	For child, impairment not severe.
N51*	Blind evaluation only--not statutorily blind.
N55	Cessation on reexamination case review.

* Indicates visual impairment alleged

B. CWD ACTION

Evaluate	Evaluate eligibility under other existing Medi-Cal linkage before denying/discontinuing client.
Deny/Discontinue Claim	If disability is the only linkage to Medi-Cal, client will be denied/discontinued.
Send Notice of Action (NOA)	If denied/discontinued, send NOA along with a copy of the Personalized Denial Notice to client.

3. NO DETERMINATION DECISIONS

"Z" codes indicate that no substantive decision was made to allow or deny a claim, and generally signify that some action is needed by CWD. After taking appropriate action, CWD should send a 90-Day Status Letter (MC 179) to client (except for Z53 and Z54 cases), if it is now the 80th day, or if it is evident that SP-DED will not be able to make a decision by the 90th day. If MC 179 is sent to client, include copy in packet being resent to SP-DED.

NO DETERMINATION CODES

Z53	Adoption of federal (SSA) denial.
Z54	Withdrawal by CWD.
Z55	CWD return for packet deficiency.
Z56	Other no determination situations (non redetermination cases).
Z57	Other no determination situations in redetermination cases only.
Z58	Other no determination situations for redetermination cases with inappropriate reexam dates.

Significance of Z Codes

Z53 Adoption of federal (SSA) denial
SSA's disability decision is controlling over Medi-Cal's decision.

Z54 Withdrawal by CWD
When CWD requests that SP-DED stop development due to withdrawal of claim, SP-DED will do so and send MC 221 to CWD. After sending NOA, no further CWD action is necessary.

Z55 CWD return for packet deficiency
This return from SP-DED means that additional information is needed. CWD will complete the information requested and forward packet to SP-DED.

Z56 Other no determination situations (non redetermination cases), AND
Z57 Other no determination situations in redetermination cases only
See below for discussion on Z56 and Z57 cases

Z58 Other no determination situations for redetermination cases with inappropriate reexam dates
If SP-DED incorrectly set a reexam date, MC 221 will be sent to CWD with a comment "inappropriate diary date". Other than removing the reexam date from CWD records, no further action is needed by CWD.

A. SP-DED ACTION IN Z56 AND Z57 DECISIONS

MC 221 Returned to CWD

SP-DED may indicate that a decision could not be made and why.

SP-DED may ask help in locating client, obtaining client's cooperation in attending a consultative exam, completing forms, or having client contact SP-DED.

B. CWD ACTION FOR Z56 AND Z57 DECISIONS

1. Evaluate If Good Cause Exists

CWD will attempt two separate contacts with client (phone, letter or in person), per Title 22, Section 50175 (a) (1) and (6), to obtain client cooperation or needed information. If good cause is claimed, determine if there is good cause for non cooperation. Good cause includes:

a. Failure of CWD to provide client with appropriate forms.

b. Failure of CWD to inform client that failure to cooperate with SP-DED will result in denial/termination.

c. Failure of postal service to deliver required form(s) or information in a timely manner.

d. Physical or mental illness or incapacity of client or authorized representative which precludes timely completion of requested information or requests to be present at scheduled appointments.

e. Level of literacy along with social or language barriers which precludes client or authorized representative from comprehending instructions.

f. Failure of CWD to properly process SP-DED packet.

g. Unavailability of transportation to reach a required destination.

If Good Cause Exists And After 30 Days of SP-DED Closure	After gaining client's cooperation, CWD must resubmit a full packet containing: 1. New MC 221, new MC 223 if a new medical condition is claimed and/or there are new or additional medical sources or information, and 2. Additional MC 220, as necessary.
If Good Cause Exists and Under 30 Days of SP-DED Closure	CWD will submit only 1. New MC 221 if there are no new allegations or treatment sources; or 2. New MC 221 and MC 223 if a new medical condition is claimed and/or there are new or additional medical sources or information, and 3. Additional MC 220, as necessary.
If Good Cause Does Not Exist	Deny application or discontinue beneficiary, if no other linkage exists.

2. Determine Whether State Hearing Was Requested

If State Hearing Requested by Client	CWD shall follow the decision of the hearing.
If State Hearing Not Requested by Client	CWD must have the client reapply.

22 C-9 -- PROCESSING REEXAMINATIONS, REDETERMINATIONS AND REEVALUATIONS

1. BACKGROUND

Cases which have had a decision made by SP-DED shall be resubmitted for another review by SP-DED for any of the following reasons:

A. reexaminations
B. redeterminations
C. reevaluations

IMPORTANT: Because the criteria for resubmitted cases differ from initial referrals, the type of referral must be correctly identified on MC 221. Include copy of prior MC 221 in SP-DED packet whenever possible to provide a more complete picture of client's overall medical condition.

2. PROCEDURES

A chart at the end of this section summarizes the procedures and identifies types of resubmitted cases, criteria for resubmitting cases, what forms to include in the SP-DED packet, and what client's eligibility status is while a SP-DED decision is pending.

A. REEXAMINATIONS

Resubmit case to SP-DED when a reexam date is due or when EW observes or receives information that the medical condition may have improved.

Submit a **full** SP-DED packet including copy of prior MC 221 and any new medical information, if received by EW. Evaluate as follows:

1. Reexam Dates Set For Expected Medical Improvement

Most reexaminations occur when a mandatory reexam date set for expected medical improvement is due. The reexam date is shown on prior MC 221.

Example: SP-DED approved case in 5/93. The condition was expected to improve and a reexam date of 11/94 was set. By 11/94, a SP-DED packet must be submitted for a reexamination.

EXCEPTION: If file shows that SP-DED adopted a Social Security Administration (SSA) allowance, contact SSA to determine whether disability continues. If SSA benefits continue, no referral to SP-DED is needed when the reexam date is due, as SSA's determination is binding until SSA revises its decision.

2. Client's Condition May Have Improved

A reexamination is also needed when EW observes or receives information that client's condition may have improved.

Example: Client becomes employed within 12 months of date of application for disability.

Example: Client came in using a walker or crutches, but is observed leaving office without their use.

Medical improvement must be proven by SP-DED prior to termination of benefits, except when there is refusal to cooperate or if whereabouts are unknown.

B. REDETERMINATIONS

This type of referral is made when client was previously determined to be disabled, was subsequently discontinued from Medi-Cal for a reason other than disability, then reapplies alleging that disability continues to exist. Evaluate as follows:

1. Decision Made **Within 12 Months** of Reapplication Date

If SP-DED's decision was made within 12 months of reapplication and reexam date is not currently due or past due, and there is no reason to suspect that client's condition has improved, reinstate client's Medi-Cal without submitting packet to SP-DED.

Example: SP-DED approved case in 5/92 with a reexam date of 5/93, and client was discontinued for reasons other than disability in 12/92 and reapplies in 2/93. Redetermination is not necessary and Medi-Cal benefits may be reinstated.

2. Decision Made **More Than 12 Months** Prior to Reapplication Date

If it has been more than 12 months since SP-DED's decision and any one of the following conditions exist, send a **full** SP-DED packet including a copy of prior MC 221:

- No reexam date was set;
- A reexam date is currently due or past due; and
- A reexam date is unknown, as in an intercounty transfer.

Example: SP-DED approved case in 5/92 with a 5/93 reexam date. Client was discontinued in 12/92 for reasons other than disability and reapplies in 6/93. A referral to SP-DED for a redetermination is necessary.

C. REEVALUATIONS

This type of referral is made **within 90 days** of SP-DED's decision when CWD believes that the SP-DED denial is incorrect. In general, a **full** SP-DED packet is needed.

EXCEPTION: When packet is sent within **30** days of SP-DED's decision, or an earlier onset date on an approved case is needed, and no new treating sources are alleged in either situation, **limited** packets consisting of the prior MC 221 and a new MC 221 may be sent. SP-DED will attempt to make a decision with the available information; however, if additional information is needed, SP-DED may return the case as a Z56 decision.

1. SP-DED Independently Reviewed Claim

Send a SP-DED packet when client, or someone acting on his/her behalf, alleges any of the following:

- Client's condition has worsened;
- There is new medical evidence not previously presented; and
- A new medical condition was not previously considered.

*Example: On 10/7/93, SP-DED denied a client who alleged disability due to heart disease. On 11/27/93, the client's husband called to inform EW that his wife has had a serious heart attack and was admitted to the hospital. Submit a **full** packet, as it is over 30 days since the prior decision.*

2. SP-DED Adopted SSA's Decision

New Condition

If SP-DED adopted SSA's denial and client has a totally **new** physical or mental condition that was not previously considered by SSA and client has decided not to appeal SSA's decision, refer case to SP-DED.

Example: An SSI claim was denied because client's leg problem was not disabling. Client then learned that he/she also has cancer, which was not considered in SSA's decision, and client decided not to appeal the SSI denial. Refer claim to SP-DED.

Same Condition

If SP-DED adopted SSA's denial and client alleges a worsening of the **same** condition which was evaluated by SSA, or has new medical evidence on the **same** condition which was not previously considered by SSA, either of which occurred **within 12 months** of SSA's denial, refer client back to SSA to appeal.

If it has been over 12 months since SSA's denial, and client has not returned to SSA to reapply, send a packet to SP-DED.

TYPE OF REFERRAL	WHEN USED (CRITERIA)	WHAT TO INCLUDE	ELIGIBILITY PENDING DED RESPONSE
Reexamination	An evaluation of disability to see if medical improvement has occurred, to be used when one of the following occurs: o DED has established a re-exam date, or; o Client becomes employed, or; o Other circumstances lead EW to believe condition has improved	o An new MC 223. (Do not photocopy old MC 223.) o MC 220s for each source. o A new MC 221 marked "Reexamination". (State the reason for reexamination in the Comments Section.) o A copy of prior MC 221. (Note on new MC 221 if not available.) o Any new medical records, if given to the EW	Eligibility continues UNLESS: o The client fails to cooperate with DED; o Whereabouts unknown, loss of contact; o DED decides client is no longer disabled and there is no other linkage; or, o Another reason for discontinuance exists, e.g., excess property.
Redetermination	Use when an applicant meets all of the following criteria: o Previously received Medi-Cal as a disabled person; o Was discontinued for a reason other than disability; and o Was determined disabled by DED more than 12 months prior to date of new application, and one of the following exists: • no reexamination date • reexamination is due or past due • reexamination date is unknown.	o A new MC 223 o MC 220s for each source o A new MC 221 marked "Redetermination". o Note "Redetermination after break in aid" in the Comments Section. o A copy of prior MC 221. (Note on new MC 221 if not available.)	o Eligibility cannot be established until DED decision is received, unless applicant meets "presumptive" disability criteria.
Reevaluation	Used when the county believes that the DED denial is incorrect and within 90 days of DED's decision. o DED independently review claim and the EW believes DED was unaware of medical evidence, conditions or recent events which could affect the decision, OR; o DED adopted an SSA denial and the client has totally new medical condition that was not previously considered by SSA and the client is not appealing SSA's decision. (If DED adopted an SSA denial and the applicant alleges his/her condition has since deteriorated or has new medical evidence which was not previously considered, do NOT do a new DED packet. Send back to SSA to appeal if SSA's decision was made within 12 months.)	o A new MC 223 (only if additional impairments, condition, or treatment sources are being reported). o MC 220s for each source o A new MC 221 marked "Reevaluation". Note: Reason for reevaluation request must be stated in the Comments Section. o A copy of prior MC 221. (Note on new MC 221 if not available.) o Any new medical reposrts, if given to EW.	• Eligibility cannot be established until DED completes the reevaluation.

22D -- DISABILITY EVALUATION DIVISION PROCEDURES

1. BACKGROUND

The Disability Evaluation Division (DED) of the State Department of Social Services is responsible for the medical determination of disability, whereas the County Welfare Department (CWD) is responsible for the non-medical portion of determining eligibility for Medi-Cal disability.

2. TWO COMPONENTS OF DED

The Federal Branches determine disability for the Social Security Administration's (SSA's) Title II program and Title XVI, the Supplemental Security Income (SSI) program.

There are two Bureaus of the State Programs (SP) Branch, one located in Los Angeles, the other in Oakland. They determine disability for Title XIX, Medi-Cal, using SSA's criteria for disability under SSI.

3. INTAKE

Upon receipt of a disability packet sent from CWD, SP-DED will perform the following activities:

Disability Packets Received	Upon receipt, packets are reviewed for completeness. If incomplete or incorrect, SP-DED returns packet with a cover letter explaining actions needed by CWD, prior to resubmitting packet to SP-DED.
Disability Packets Accepted	If complete, packets are accepted and pertinent applicant information is entered into SP-DED's computer.
Case Assigned	Cases are assigned to a medical review team: a Disability Evaluation Analyst (DEA) and a Medical Consultant (MC), a medical doctor. The DEA/MC team assesses medical and vocational factors in disability claims.
Case Queried	Cases are queried via the SP-DED computer system to determine if there is a federal Title II or Title XVI disability claim pending. No valid federal decision available or pending claim: SP-DED processes the claim and makes an independent determination.

Valid federal decision available: SP-DED adopts the federal decision.

Pending federal claim: SP-DED assesses the status of the pending claim and either initiates development or waits to adopt the federal decision.

4. CASE PROCESSING

SP-DED develops cases to obtain all necessary medical or other relevant evidence, such as a vocational and/or social history. SP-DED performs the following activities:

Obtains Medical Evidence

Medical evidence is needed to document impairments in terms of specific signs, symptoms and laboratory findings.

Makes Client Contact

Client contact may be made to obtain additional information. Client may also be asked to go to a consultative examination paid for by the state. If contact is unsuccessful, claim may be returned to CWD for assistance in contacting client or obtaining necessary cooperation to process claim.

Applies Disability Criteria

Medical criteria for Disability are based on SSA's Listing of Impairments which contain over 100 medical conditions that would ordinarily prevent an adult from working or, for children, from performing age appropriate activities.

Assesses Vocational Factors For Adults

Vocational factors are assessed to determine client's ability to do work-related activities when a finding of disability cannot be made on medical considerations alone.

Assesses Age-Appropriate Activities For Children

When a finding of disability cannot be made on medical considerations alone, SP-DED assesses a child's ability to function independently and effectively in an age-appropriate manner.

Initiates Presumptive Disability (PD)

When a PD decision has not been made and client has a condition for which PD can be granted, SP-DED will alert the CWD and document the PD decision.

Performs Medical Deferment

Cases can be medically deferred for up to three months when future evidence is needed to assess duration and severity of an impairment.

Medical deferment is an exception to the rule, rather than a routine procedure. Common reasons are strokes or heart surgery.

Documents Decision

When a decision is made, it is explained on MC 221 or its attachment. The original copy is sent to CWD.

NOTE: If a decision is less than fully favorable, CWD may use the Personalized Denial Notice to explain to client the reason for the decision, but should **not** send a copy of the MC 221 or its attachment with client's Notice of Action.

Performs Reexaminations

When a reexam date arrives, CWD **must** submit cases for a medical review by SP-DED, except for decisions which were adopted from a federal claim.

Disability ends if evidence shows there is medical improvement related to the ability to work, or the ability to engage in age-appropriate activities in Disabled Child cases.