22C-3--DETERMINING PRESUMPTIVE DISABILITY

1. BACKGROUND

Presumptive Disability (PD) decisions allow a temporary granting of Medi-Cal eligibility pending a formal determination by State Programs-Disability Evaluation Division (SP-DED). PD categories and documentation requirements are established according to federal regulations.

PD Requirements--County Welfare Departments (CWDs) May Grant a PD When:

- The client has a condition that is listed in the "PD Categories" in Section 22C-3;
- The condition is verified by a doctor/medical source;
- There was no Title II or Supplemental Security Income (SSI) disability denial in the past 12 months (unless PD is based on a new medical condition not previously considered by Social Security Administration (SSA)); *and*
- The client is otherwise eligible.

IMPORTANT: If the individual had a federal (i.e., Title II or SSI) denial within the past 12 months, the federal denial is binding on Medi-Cal for 12 months from the date of the most recent federal decision (i.e., the initial application, reconsideration, hearing, or appeals council review). In such cases, the CWD cannot grant a PD *unless* the individual alleges a new medical condition that was not previously considered by SSA *and* all of the PD requirements specified above are met.

REMINDER: Only SP-DED can grant PD for medical conditions that are not listed on the PD categories chart.

2. RESPONSIBILITIES OF THE CWD AND SP-DED

A. CWD

1. *Impairment* — Check the PD categories chart on page 22C-3 to ensure the client's medical condition is listed. ***It must match the disability exactly.***

2. *SSA denial* — Check for a prior SSA disability denial within the past 12 months. CWD will need to contact SSA if prior SSA denial exists, **do not** grant PD **unless** the client alleges a new medical condition that exactly matches a PD category **and** the new impairment was not previously considered by SSA. If the client alleges a favorable SSA decision within the past 12 months, but a final SSA decision has not yet been made, the SSA decision was most likely a SSI PD. The CWDs should only PD an MNO case IF the applicant's condition fits a PD category and has medical documentation to verify this.

3. *Medical Statement Provided*

The client's doctor/medical source must verify the impairment on a signed and dated document.

If there is a delay in obtaining verification from the applicant or medical source, **DO NOT** hold the DED packet. The county must forward the packet to SP-DED as SP-DED can also grant PD.

4. *MC 221*

In Item 10 of the MC 221:

- o Check the "PD approved" box, and
- o Document basis for PD determination (i.e., impairment/medical condition) using only the impairments listed on the PD categories chart.

5. *Effective date*

PD determinations shall be granted beginning in the month that the MC 221 is completed and medical verification is obtained.

Do not grant PD from the month of application, unless the required medical verification and the MC 221 are completed in the month of application.

Under no circumstance is the county to grant PD for any past months, i.e. retroactively.

6. *Notice to client*

Notify the client via a Notice of Action (NOA). Explain to the client that PD temporarily grants Medi-Cal eligibility pending a formal decision by SP-DED.

7. *Reference*

Before sending the disability packet, review the "Presumptive Disability Checklist" on page 22C-6.13 to ensure accurate PD determinations.

B. SP-DED

1. *CWD Notification*

If CWD did not grant PD and SP-DED finds at any point in case development that client meets PD criteria as shown in the PD chart, **OR** that available evidence indicates a strong likelihood that disability will be established on formal determination, the appropriate CWD liaison will be contacted by phone/fax.

2. *MC 221*

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

If PD decision is phoned to CWD, a photocopy of the MC 221 will be mailed to CWD liaison as verification that PD was granted/denied.

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 of MC 221: "Previous PD decision not supported by additional evidence".

C. PD IN URGENT CASE SITUATIONS

On occasion, CWDs or SP-DED may learn about a client who: 1) is in dire need of an immediate disability decision because of a **disabling** condition which will prevent work activity for 12 months or longer, **and** 2) cannot wait for a formal decision because the delay will pose significant problems to his/her functioning and well-being.

1. SP-DED Criteria to Grant PD for Urgent Case Requests

Prior to granting PD, SP-DED must evaluate specific criteria to ensure that client will meet disability requirements when a formal decision is made. SP-DED must determine if the available evidence, short of that needed for a formal decision, shows a strong likelihood that:

- Disability will be established when complete evidence is obtained,
- The evidence establishes a reasonable basis for presuming the individual is currently disabled, and
- The disabling condition has lasted or is likely to last at least 12 months.

2. CWD Urgent Case Requests to SP-DED

CWDs may make an urgent case request to SP-DED after screening the case for the SP-DED PD criteria and ensuring that client is otherwise eligible. CWDs are urged to make the urgent case request via **fax** rather than mail to expedite SP-DED's consideration of a PD decision.

Four ***examples*** of urgent case requests that may be referred to SP-DED are as follows:

a. *Client suffered massive head and internal injuries, is comatose, and needs an immediate Medi-Cal decision for transfer to a facility which specializes in head trauma. While client is expected to survive, client is expected to be dependent on a wheelchair for the rest of his life.*

b. *Client has lung cancer which has spread to the spine and vital organs. Doctor states client is expected to live six to 12 months longer, even with treatment, and needs aggressive therapy immediately.*

c. *Client has irreversible kidney failure caused by uncontrolled high blood pressure and is now on renal dialysis. Hospital records and doctors' outpatient notes include lab studies which confirm that kidney function has decreased over the past year and dialysis is required for client to survive. An immediate Medi-Cal decision is necessary to transfer client to an outpatient renal dialysis clinic.*

d. *Client has severe diabetes. Doctor states a below knee amputation must be performed because of gangrene caused by poor circulation of both legs. Doctor sends reports from earlier hospitalizations, lab studies, progress notes, and a letter specifying the immediate need for a disability decision so that client can be hospitalized for surgery.*

3. CWD Actions

a. CWD receives urgent case request from doctor/medical facility; CWD asks for **faxed** medical reports to verify severity of client's condition (e.g., hospital admission and/or discharge summaries, outpatient progress reports, x-ray reports, pathology reports, lab studies and other reports pertinent to the disability).

b. CWD determines that client is **otherwise eligible** and screens request to ensure the SP-DED PD criteria will likely be met. CWD liaison **faxes** a full disability packet and medical reports to the following numbers:

Los Angeles Branch: **FAX (800) 869-0188**
Oakland Branch: **FAX (800) 869-0203**

Enter comment in Item 10 of MC 221: "Please evaluate for PD" and "Attention: Operations Support Supervisor". CWD fax number should be entered in Item 11 of MC 221.

c. CWD should not delay sending packet prior to receipt of medical reports confirming severity of condition for urgent case request.

d. CWD alerts SP-DED via phone/fax about an urgent case request if packet has already been sent and follows-up by faxing medical reports with an MC 222 (DED Pending Information Update Form). Specify in Item 10 of MC 222: "Urgent Case Request-Medical Reports Attached" and "Packet sent on (date)".

4. SP-DED Actions

a. SP-DED immediately reviews request and ensures, via systems query, that client has not been previously denied by SSA. If more information is needed to reach a PD decision, the medical source is **phoned** and asked to **fax** additional medical reports.

b. SP-DED strives to notify CWD liaison **by phone** OR **by faxing** a copy of the MC 221 within two working days, if possible, about its PD decision. If notification is made by phone, SP-DED mails a photocopy of MC 221 to advise CWD liaison whether PD is granted/denied. Item 16 of MC 221 shows: "PD granted/denied; phoned/faxed to CWD liaison; received by (name of contact) on (date)".

c. SP-DED continues processing case as quickly as possible to make a formal decision. If PD was granted and disability is not established when a formal decision is made, Item 16 of MC 221 will show: "Previous PD decision not supported by additional evidence".

D. REMINDERS

1. The PD effective date is the month in which SP-DED makes its determination that client meets PD requirements.

2. PD is granted **prospectively** only i.e., the month in which the MC 221 is completed and signed medical verification is in file. **PD may be granted in the month of application IF the CWD obtains the required medical documentation and completes the MC 221 in the month of filing. Never grant PD retroactively.**

3. Before granting PD, client must be otherwise eligible.

4. PD cannot be granted if client is performing Substantial Gainful Activity (SGA). SGA is discussed in Article 22 C-3.

5. CWD should not delay sending packet to SP-DED pending to receipt of medical reports confirming severity of client's condition for an urgent case request.

3. PD CATEGORIES

CWDs may grant PD when client meets any of the following conditions. SP-DED granted PDs are not limited to the categories shown below:

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--exclude recent accident and recent surgery.
6	Allegation of a 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 the hands or arms.
8	Allegation of diabetes with amputation of a foot.
9	Allegation of Down syndrome.
10	Allegation of severe mental deficiency made by another individual filing on behalf of a client who is at least 7 years of age. For example, a mother filing for benefits for her child states that the child attends (or attended) a special school, or special classes in school, because of mental deficiency, or is unable to attend any type of school (or if beyond school age, was unable to attend), and requires care and supervision of routine daily activities. **NOTE:** "Mental deficiency" means mental retardation. This PD category pertains to individuals whose dependence upon others for meeting personal care needs (e.g., hygiene) and in doing other routine daily activities (e.g., fastening a seat belt) grossly exceeds age-appropriate dependence as a result of mental retardation.
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.)
13	A child is age 6 months or younger and available evidence (e.g., the hospital admission summary) shows a gestational age at birth on the table below with the corresponding birth-weight indicated: **Gestational Age (in weeks)** — **Weight at Birth** 37-40 — Less than 2000 grams (4 pounds, 6 ounces) 36 — 1875 grams or less (4 pounds, 2 ounces) 35 — 1700 grams or less (3 pounds, 12 ounces) 34 — 1500 grams or less (3 pounds, 5 ounces) 33 — 1325 grams or less (2 pounds, 15 ounces)
14	A physician or knowledgeable hospice official confirms an individual is receiving hospice services because of terminal cancer.

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)".

PRESUMPTIVE DISABILITY CHECKLIST

The use of this checklist will help to ensure accurate PD determinations made by counties.

MC 221 (6/93 revision) See the Medi-Cal Eligibility Procedures Manual Section 22C-3

( )	Does the client's impairment exactly match an impairment on the PD categories chart? CWD should PD **only** if there is a match.
( )	Has there been a prior SSA/SSI denial within the past 12 months? If yes, do not PD unless client alleges a new medical condition that exactly matches the PD categories chart and SSA did not previously consider the new impairment.
( )	Is there a signed and dated verification of the disability/impairment from the applicant's physician or medical source? Is a copy in the DED packet?
( )	Is Item 10 on the MC 221 marked "PD approved" and is the basis for PD (i.e., impairments) documented using only the impairments listed on the PD categories chart?
( )	Send the DED packet to SP-DED immediately if there is any doubt of the impairment or verification is lacking or will be delayed. SP-DED can initiate a PD determination if the medical evidence supports it.
( )	Is the effective date of the PD the month in which the MC 221 is completed and PD medical verification is obtained?

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 (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.)

DHS 7038 A(Coversheet) (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 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. Proceed to Section E if you have any remarks you want to make about the patients 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
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 to the 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: _____

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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 (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 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**

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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

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. Proceed to Section E if you have any remarks you want to make about the patients condition. Then proceed to Sections F and G and sign and date the form.

D. OTHER MANIFESTATIONS OF HIV INFECTION:

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

_____

_____

_____

AND

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

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

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

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

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

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

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

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

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

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

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

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

   c. **Age 3 to Attainment of Age 18**—Limitation in at least 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

I declare under penalty of perjury under the laws of the United States of America and the State of California that the information contained to the 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:

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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