27. DDSD

27.1 Federally Disabled Persons [50167, Proc. 22C]

27.1.1 Overview

Medi-Cal eligibility for disabled persons is determined concurrently by: (1) County Welfare Departments (CWDs) and (2) the State Programs - Disability Determination Service Division (SP-DDSD) of the California State Department of Social Services (CDSS). The CWD is responsible for the non-medical part of the eligibility determination; SP-DDSD (hereafter referred to as DDSD) is responsible for the collection of medical data and the disability determination. (Reference: California Administrative Code [CAC], Title 22, Section 50167 [a] [1] [A-B]).

• Disability benefits established through State Disability Insurance (SDI), Veterans' Benefits, and Workers’ Compensation Fund, do not establish disability for Medi-Cal. These benefits establish incapacity deprivation only, not disability. Disability must be determined or verified according to the following disability referral process at each application, regardless of previous disability determinations for any case.

• Eligibility for Medi-Cal under the In-Home Medical Care Service Waiver does not qualify the individual as disabled for other Medi-Cal programs.

27.1.2 Definition

Federal law defines a person 18 years of age or older as disabled if that person meets the Social Security Administration's disability criteria for RSDI or SSI/SSP. State law requires that Medi-Cal clients 21 through 64 years of age who allege disability must have their eligibility evaluated under the Aged, Blind and Disabled-Medically Needy (ABD-MN) Program. This is because the Medi-Cal costs of MN eligibles are approximately 50 percent federally funded, and the ABD-MN Program is more advantageous to the applicant/beneficiary due to the greater income deductions.
27.1.3 Duration

The condition of disability must be expected to result in death or has lasted or can be expected to last for a continuous period of at least 12 months in order for a person to be considered federally disabled. Also, it must prevent a person from working. [Refer to “Determining Substantial Gainful Activity (SGA),” page 27-18.] The 12-month disability period is determined from the first day the client is unable to work due to that disability.

Note:
A disabled working individual may be considered for the 250% Working Disabled Program.

27.1.4 Other Linkage

A DDSD referral must be made on other Medi-Cal applicants or recipients who are eligible under another program (e.g. AFDC-MN/MI), and who allege disability and choose to apply or be redetermined as disabled MN.

Note:
A child who is determined to be disabled may have a lower share of cost than an AFDC-MN child due to the greater income deductions available to both the child and his/her parents.

27.2 DDSD Referral Not Required

A disability referral is not required when one of the following disability verifications is available and the date of disability onset and reexamination dates are documented in the case record:

• The person was eligible as an MN person on the basis of blindness or disability in December 1973, and there has been continuing eligibility since that time.

• A Social Security award letter or an SSI/SSP award letter showing disability; provided the applicant is still receiving these benefits.

• When a client is under 65 and receiving RSDI, it must NOT be assumed these benefits are issued based on disability. The SSA award letter or notice of increased/decreased disability benefits must be seen.
• Social Security checks cannot be used as verification since they do not state that the payment is for disability. Other verification must be provided.

• Social Security notice of increased/decreased disability benefits; provided the applicant is still receiving these benefits.

• Social Security statement of a person's eligibility on the basis of disability.

• Railroad Retirement Board (RRB) disability award letter, providing the letter states that the applicant is totally and permanently disabled and the applicant is still receiving these benefits. If RRB benefits were issued based on occupational disability, the applicant is not disabled for Medi-Cal purposes. A DDSD packet must be completed for these applicants. The packet must include an “Authorization for Release of Information” (MC 220) authorizing DDSD to obtain copies of the RRB awards.

• The applicant is totally and permanently disabled, and a MEDS screen printout or a signed statement from Social Security confirms that a person was discontinued from SSI/SSP for reasons other than cessation of disability. They are still considered to be disabled for Medi-Cal if they are currently receiving Social Security disability Title II benefits. Persons discontinued from SSI/SSP are referred to as “Craig” (formerly “Ramos”) individuals. [Refer to “DDSD — Special Referrals,” page 31-1, and “Procedures became effective January 1, 1982 and became obsolete effective June 30, 2002. The Craig v. Bontá lawsuit superseded the Ramos v. Myers court order,” page 67-19.]

• A prior DDSD determination was made within the last 12 months and the reexamination date has not yet come due and there is no indication that the medical condition has improved.

27.3 Who Should Not Be Referred to DDSD

There are situations when a DDSD referral is not appropriate. EWs must check for prior SSA or DDSD decisions (available in the case/system/IEVS) that are still currently in effect prior to sending disability referrals.

<table>
<thead>
<tr>
<th>Situation</th>
<th>DO NOT refer a client:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prior DDSD Decision - Disabled</td>
<td>Who had a prior DDSD decision made within the past 12 months unless the reexamination date is due or has passed, or there is an indication that the medical condition has improved.</td>
</tr>
</tbody>
</table>
A DDSD referral is appropriate when the client alleges disability and meets any of the following conditions:

<table>
<thead>
<tr>
<th>Condition</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>No Prior SSA Evaluation</td>
<td>Client’s disability has never been evaluated by Social Security.</td>
</tr>
</tbody>
</table>
| SSA Application Status is Unknown  | Client’s application for SSA Title II or SSI Title XVI is unknown and attempts to verify the status have not been successful.
| or Pending                         |                                                                            |
Reminder:
EWs must check for prior SSA or DDSD decisions (available in the case/system/IEVS) that are still currently in effect prior to sending disability referrals.

When previously stated methods of disability verification are not available, a referral to DDSD must be made on any applicant or beneficiary who is potentially disabled as indicated by the following:

### 27.4.1 MC 210

The client has checked “Yes” that he/she has a physical, mental or emotional disability on Question 23 of the “Application for Medi-Cal” (MC 210).

<table>
<thead>
<tr>
<th>Condition</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>SSA Application Denied Due to Excess Income/Resources</td>
<td>Client’s application for SSI Title XVI is denied due to excess income/property and client meets property requirements for Medi-Cal.</td>
</tr>
<tr>
<td>SSA Approved Claim</td>
<td>SSA has approved the client’s disability claim AND the client is requesting retroactive Medi-Cal coverage prior to SSA’s disability onset date.</td>
</tr>
<tr>
<td>SSA Denied Claim</td>
<td>SSA denied disability claim:</td>
</tr>
<tr>
<td></td>
<td>• Within or over 12 months ago and client alleges a <strong>new</strong> condition not previously considered by SSA, and has not reapplied with SSA.</td>
</tr>
<tr>
<td></td>
<td>• Over 12 months ago and same condition has worsened, and has not reapplied with SSA.</td>
</tr>
<tr>
<td>SSA Discontinued Claim</td>
<td>SSA discontinued SSI Title XVI benefits for reasons other than disability and client still has the same medical condition which was the basis for the prior SSI approval. A limited packet is sent to find out the reexam date. [Refer to “Procedures became effective January 1, 1982 and became obsolete effective June 30, 2002. The Craig v. Bontà lawsuit superseded the Ramos v. Myers court order,” page 67-19] [Refer to “Limited DDSD Referral,” page 31-1], and [Refer to “Referral for Former SSI/SSP Recipient - Discontinued for Reasons Other than “Cessation of Disability”,” page 31-3.]</td>
</tr>
<tr>
<td>SSA Refuses to Reopen Claim</td>
<td>SSA, at its discretion, refuses to accept a reopening request.</td>
</tr>
<tr>
<td>Railroad Retirement Board (RRB) Disability</td>
<td>RRB determined Occupational Disability only.</td>
</tr>
<tr>
<td>Good Cause</td>
<td>Client was denied Medi-Cal benefits for failure to cooperate with DDSD and good cause is established.</td>
</tr>
</tbody>
</table>
When an applicant indicates a disability on the MC 210, the EW must explain the DDSD referral process to the potentially disabled person. In order for DDSD to approve the referral, the applicant's disability must:

- Meet conditions of medical impairment. The disability must be severe, and have lasted or be expected to last for a continuous period of at least 12 months or is expected to result in death, and
- Limit the person from physically or mentally performing past work or other work which would produce limited income.

The information notice “What You Should Know About Your Medi-Cal Disability Application” (MC 017) should be given to the applicant. It provides a summary of the disability evaluation process.

<table>
<thead>
<tr>
<th>If the applicant...</th>
<th>Then...</th>
</tr>
</thead>
<tbody>
<tr>
<td>Decides not to apply for Medi-Cal as a disabled person, for example, condition is not severe,</td>
<td>The applicant must cross out the “Yes” answer on Question 23, mark “No” and initial the change. The EW must thoroughly document the reason for the change.</td>
</tr>
<tr>
<td>Still wants to be referred to DDSD</td>
<td>The EW must process the referral.</td>
</tr>
<tr>
<td>Answers “Yes” but is already linked (for example, to AFDC-MN),</td>
<td>The applicant may choose whether or not to be referred. EWs must explain that there are greater income deductions for ABD-MN.</td>
</tr>
</tbody>
</table>

### 27.4.2 Blindness

If the client is aged (over 65), a DDSD referral must not be made UNLESS blindness is claimed.

- A blindness evaluation for a former SSI/SSP recipient for a determination under the Pickle Amendment to the Social Security Act may be necessary even if the applicant/beneficiary has reached age 65; or, has already been determined to be disabled. This is because a blind individual is entitled to a higher SSI/SSP payment level than a disabled or aged person. (The EW must check “Pickle-Blind” on Item #8 of the “Disability Determination and Transmittal” (MC 221), or DDSD may reject the referral as unnecessary.)
- DDSD will also do a blindness evaluation for an employed person over age 65 due to possible entitlement for an additional income deduction.
27.4.3 Client's Statement

The applicant/beneficiary makes a written or oral statement to the EW which alleges disability.

27.4.4 RSDI/SSI Pending

The client states that he/she has an RSDI or SSI/SSP disability (including blindness) determination pending.

27.4.5 Presumptive Disability

The client has a letter from a physician verifying a condition of “presumptive disability.” [Refer to “DDSD — Presumptive Disability (PD),” page 33-1 for presumptive disability conditions and procedures.]

27.5 Promptness

The county is required to submit the disability packet to DDSD within ten calendar days of the date the applicant submits a completed “Applicant's Supplemental Statement of Facts for Medi-Cal” (MC 223) or “Supplemental Statement of Facts for Medi-Cal Child Applicant Only - Under Age 18” (MC 223C).

Note:

An MC 223 or MC 223C cannot be submitted in lieu of an MC 210. Social Services Agency must first receive an MC 210 to determine that the client is alleging a disability.

It is not always possible, for reasons which are beyond the EW's control, (such as failure of the applicant to sign an MC 220 in a timely manner) to submit the disability packet within the required 10 days. Such exceptions must be documented in the case record clearly stating the reason for late submission of the packet as well as the date the applicant provided all necessary information. However, do not hold the referral to DDSD pending verification of other non-disability factors.

Example:

Client claims disability on the MC 210 and completes the MC 223 or MC 223C. The client fails to provide all the signed releases (MC 220) within 10-days. The EW documents the missing information as the reason for not sending the
referral within 10 days. The client subsequently provides the MC 220s but fails to provide verification of property. After reviewing all the information submitted and personally contacting the client, the client appears to be eligible. The EW documents the date all information and forms were received and sends the referral to DDSD pending verifications. After the DDSD referral is sent, the client provides verification of property and is found to be over the property limit. The client is denied Medi-Cal and the worker sends an MC 222 informing DDSD that the client is ineligible so that the disability evaluation can be stopped.

EWs must send a “90-Day Status Letter” (MC 179) when the DDSD packet has not been forwarded to DDSD by the 80th day from the date of the disability-based application. [Refer to “DDSD — EW Procedures,” page 30-1.] The MC 179 is also available in CalWIN.

### 27.6 RSDI/SSI Pending

For DDSD applicants who claim to have an RSDI and/or SSI disability application pending, the following actions are required:

<table>
<thead>
<tr>
<th>STAGE</th>
<th>DESCRIPTION</th>
</tr>
</thead>
</table>
| 1     | The EW completes a full DDSD packet when the applicant has a pending application for RSDI and/or SSI. (Note on the MC 221 that there is a pending RSDI and/or SSI application.)
     NOTE: A full DDSD packet is required as applicants may believe they have applied for these two programs, but in actuality have applied for worker's compensation, state disability benefits, etc. If DDSD discovers that no federal evaluation is being completed, all forms necessary for a medically needy evaluation are available if a complete packet is submitted. |
| 2     | DDSD holds the MC 221 until the final federal disability determination is made. The application must be held pending until the DDSD determination is completed unless other criteria makes the applicant ineligible. This may take up to six months or longer. |
| 3     | DDSD returns the MC 221 along with an attached “DDSD disability Determination - Response to MC 221” (SP2 DDSD 221R) or (SP4 DDSD 221R) to the EW stating the onset date, reexamination date, or the original date of the federal denial, when the final federal disability determination is made. |
| 4     | DDSD processes the packet and completes an independent disability evaluation when:  
     • There is no pending federal application,  
     • The county has indicated the disability determination is urgently needed, or  
     • If the federal determination will not be completed within reasonable time limits. |
27.7 Retro Onset Dates

For SSI recipients who request three months retroactive Medi-Cal coverage, the EW must request a disability onset date.

- EW sends a communication form “Referral of Applicant to SSA” (SCD 169) or “Referral To/From Social Security,” (SC D 1955) to Social Security to determine the disability onset date.

- If the onset date provided by SSA is later than the month(s) of request for retroactive Medi-Cal coverage, the EW must initiate a new referral by completing a full DDSD packet.

Reminder:

The “Retro-onset” box on Item 8 of the MC 221 must be checked.

[Refer to “DDSD Referral for a Retro Month,” page 31-2] for information about DDSD referral requirements for retro months.

27.8 Disability Determination Service Division (DDSD)
Referral Limited by SSA Decision

27.8.1 Overview

The 1990 federal disability regulations state that the Social Security Administration (SSA) controls disability determinations. Under these regulations DDSD is not allowed to make an independent disability determination if the applicant claims the same disabling condition previously considered by Social Security within the past 12 months. Social Security’s determination is binding unless revised by them.

It is important to know if a client has been denied Social Security disability or SSI within the past 12 months. Clients must first be screened to determine if a DDSD referral should be completed. Then, determine if a client requesting a DDSD disability determination has also filed for RSDI (Title II) and/or SSI disability benefits
(Title XVI) within the last two years. If it is found that the client has filed for Social Security disability benefits within the past two years, EWs must determine if the applicant should still be referred to DDSD.

Note:
Two years is the period of time for requested information because clients may have applied for RSDI/SSI more than 12 months ago, but the actual Social Security determination may have been made within the past 12 months.

The client’s answers to Questions 5 a-d on the MC 223 (Part 3 questions A-D on the MC 223C for applicants under the age of 18) determine whether the disability based Medi-Cal application should be referred to DDSD or denied. The “Screening Form/SP-DDSD Applicants” (SCD 96), duplicating these questions may also be used. The form is completed by persons applying for Medi-Cal based upon disability. Prior to issuing the MC 223 (MC 223C for applicants under the age of 18), EWs must review this form to determine if a DDSD packet is necessary.

27.8.2 Conditions

A DDSD referral will not be made by EWs under the following conditions:

• Social Security has denied a claim based on disability within 12 months of the client’s Medi-Cal application, AND

• The applicant states on the MC 223 (for over age 18) or MC 223C (for under age 18) that the same disabling condition(s) denied by Social Security has NOT worsened or changed, and that no new condition(s) exist, OR

• The applicant states on the MC 223 (for over age 18) or MC 223C (for under age 18) that the same disabling condition denied by Social Security has worsened or changed. (Only if additional or new changes are declared, will a DDSD referral be made.)

Note:
To restate the above, regardless of whether the condition has or has not worsened, do not send a referral to DDSD if SSA denied the claim within the last 12 months.

Example:
Client’s claim for the current condition was denied by SSA eight months ago. His condition has worsened and now meets the presumptive disability criteria. Do not send a referral to DDSD as this condition was denied by SSA within the last 12 months.
An applicant who is not sure if a Social Security denial was received within the past 12 months will have a DDSD referral completed by the EW. DDSD will inform the EW through the MC 221 of their decision.

### 27.8.3 Screening Form

To assist EWs in determining whether or not a DDSD referral should be completed, “Screening Form/DDSD Applicants” (SCD 96) can be used. This form duplicates questions 5 a-d on the MC 223 (Part 3, questions A-D on the MC 223C for applicants under age 18). Do not have a client complete an MC 223 (for over age 18) or MC 223C (for under age 18) unless it is first known whether or not a Social Security disability claim has been filed within the past two years.

### 27.8.4 Completion of MC 223 or MC 223C

Once a client begins to fill out the MC 223 (for over age 18) or MC 223C (for under age 18), the following actions are required:

- EWs may STOP after question 5d of the MC 223 (Part 3, question D on the MC 223C for applicants under the age of 18) if the client's answers indicate a DDSD referral need not be completed.

- EWs who stop after question 5d (Part 3, question D on the MC 223C for applicants under age 18) MUST NOTE in the right hand margin of the MC 223 or MC 223C: “Client informed and understands that due to a Social Security disability/SSI denial within the last 12 months, a DDSD packet cannot be sent.”

- The client must sign and date page 7 of the MC 223 (page 9 of the MC 223C for applicants under the age of 18), as evidence that the client received this verbal information.

### 27.8.5 Informing Notice/NOAs

An applicant whose Medi-Cal application based upon disability is denied due to a prior Social Security decision MUST be referred back to SSA. When a DDSD referral is denied, the EW must give the client special notice "Important Information Regarding your Appeal Rights" (MC Information Notice 13) and document this was done. A Notice of Action "Denial Due to a Federal Social Security Disability Determination" (MC 239 SD) must also be issued to the client, advising of the denial for Medi-Cal benefits based upon disability.
27.8.6 Referring Clients to Social Security

When a DDSD referral is denied and the client is referred back to Social Security, every effort should be made to confirm (but it is not required) that there has been a Social Security disability denial determination within the past 12 months. The client should take the “MC Information Notice 13” to Social Security when appealing a disability denial. This will help minimize confusion and aid in the client's appeal with Social Security.

The applicant’s IEVS report includes information about Social Security/SSI denial, if or when the client filed a Social Security/SSI appeal, and the status of the appeal.

Clients who appeal Social Security Administration's denial of disability have three options:

• File for a reconsideration. For a denied claim to be reconsidered by Social Security, clients must file the reconsideration within 60 days from the date the notice denying disability was received. Good cause may be considered by Social Security for clients who file after 60 days.

• File for a reopening. Social Security may reopen an SSI determination made within one year for any reason and within two years for good cause. A reopening is not a right nor generally a requirement. Social Security is not obligated to reopen, and has the discretion to determine if there is cause to reopen a claim.

• File a new application for disability with Social Security.

Note:
Clients who have additional questions regarding their appeal rights should be referred to the Social Security Administration.

27.8.7 SSA Approves Disability After Originally Denying Claim

If the EW denies Medi-Cal based on a Social Security Administration (SSA) denial within the last 12 months and SSA subsequently approves the disability claim, the EW must rescind the denial and approve Medi-Cal, if the client is otherwise eligible.

A new application or DDSD referral is not needed if the SSA disability onset date coincides with our beginning date of aid.

If retro Medi-Cal is needed, send a full DDSD packet to the DDSD office including the SSA award letter. Indicate in Item #5 of the MC 221 the initial Medi-Cal application date and specify “client was originally denied and referred to SSA for reopening.”
Note:
A request for retro Medi-Cal must be made within one year of the month for which retro is requested.

27.8.8 Discontinuance of SSA Disability Benefits - “Cessation of Disability”

When a Medi-Cal client is discontinued from Social Security Disability Benefits due to “cessation of disability”, linkage to the Medi-Cal program as a disabled person continues until the SSA disability decision becomes “final.”

The SSA disability decision becomes “final” only when the client does not or cannot appeal the decision any further.

Social Security Appeal Process

Social Security has 3 levels of appeal:

• Reconsideration,
• Administrative Law Judge (ALJ) Hearing, and
• Appeals Council Review.

SSA allows the client 65 days to file an initial appeal request or an appeal request at the next level. The 65 day period starts from the:

• Date of the SSA termination notice, or
• Date of the latest appeal decision.

The client may choose to pursue all three levels of appeal or may not file an appeal at all. Therefore, the SSA decision will take anywhere from 65 days to 3 years or longer to become “final.”

EW Action

When a Medi-Cal client reports the termination of SSA disability benefits, the EW must determine if the termination is due to “cessation of disability” and when the SSA decision becomes “final” by:

• Asking the client if an appeal has been or will be filed.
• Verifying the SSA appeal status via “Referral To/From Social Security” (SCD 169) or another form of verification submitted by the client.
Once it is verified that an SSA appeal is pending, the EW must set up an alert in CalWIN for SSA appeal status follow-up at each annual redetermination until a “final” decision is rendered. Only after the SSA decision has become “final” must the EW take action to:

- Redetermine on-going Medi-Cal eligibility under another linkage factor (e.g., AFDC-MN), or discontinue Medi-Cal with a 10 day NOA if no other linkage exists.

### 27.8.9 Discontinuance of SSI/SSP Disability Benefits - “Non-Disability Reasons”

When the client's SSA benefits have been suspended or terminated for non-disability related reasons (such as excess income or property), the client’s case must be processed as an “INITIAL REFERRAL.”

Submitting the claim as an initial referral, rather than a reexamination, requires a FULL disability packet. Also, any current work activity must be evaluated by the EW to determine if Substantial Gainful Activity (SGA) exists. Cases in which the applicant is working and the EW has not made an SGA determination will be returned without a disability determination.

**Exception:**
SGA determinations are not applicable to clients applying for the 250% Working Disabled Program.

27.9 Disability Determination Service Division (DDSD) Decision Chart

This decision chart shows when a DDSD referral must be made, and when a DDSD referral must be denied. “RSDI” refers to Social Security disability, or Title II disability. “Denied RSDI or SSI” includes denials and discontinuance of benefits.

<table>
<thead>
<tr>
<th>If the client...</th>
<th>And the client...</th>
<th>Then the EW must...</th>
</tr>
</thead>
<tbody>
<tr>
<td>Has not applied for RSDI or SSI benefits,</td>
<td>Is not required to apply for RSDI,</td>
<td>Complete a DDSD referral.</td>
</tr>
<tr>
<td>Has applied for RSDI or SSI,</td>
<td>States the RSDI or SSI application is pending</td>
<td>Complete a DDSD referral.</td>
</tr>
<tr>
<td>Has been denied RSDI or SSI (regardless of the denial date),</td>
<td>Claims a new or different disabling condition from the one denied by Social Security,</td>
<td>Complete a DDSD referral.</td>
</tr>
<tr>
<td>Has been denied RSDI or SSI</td>
<td>Within the past 12 months</td>
<td>Deny Medi-Cal based upon disability and refer client to Social Security to appeal. Issue MC 239 SD and MC Information Notice 13.</td>
</tr>
<tr>
<td></td>
<td>More than 12 months ago,</td>
<td>Complete a DDSD referral.</td>
</tr>
<tr>
<td></td>
<td>Claims the disabling condition denied by Social Security has worsened or changed,</td>
<td>NOTE: Send a copy of SSA denial letter with the DDSD packet.</td>
</tr>
<tr>
<td>Has been denied RSDI or SSI</td>
<td>Does NOT claim that the disabling condition denied by Social Security has worsened, or that a new condition exists,</td>
<td>Deny Medi-Cal based upon disability and refer client to Social Security to appeal. Issue MC 239 SD and MC Information Notice 13.</td>
</tr>
<tr>
<td>• Within the past 12 months OR</td>
<td></td>
<td>NOTE: Denial may be rescinded if SSA subsequently approves the disability claim.</td>
</tr>
<tr>
<td>• More than 12 months ago</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### SSA/DDSD-SP Client Referral Chart

The following chart helps to identify where the claim should be referred:

<table>
<thead>
<tr>
<th>Client Status with SSA</th>
<th>Situation</th>
<th>Where to Refer</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Did not apply</td>
<td>N/A</td>
<td>DDSD</td>
</tr>
<tr>
<td>2. Applied</td>
<td>Application status unknown.</td>
<td>DDSD</td>
</tr>
<tr>
<td>3. Pending</td>
<td>Application status is pending.</td>
<td>DDSD</td>
</tr>
<tr>
<td>4. Approved</td>
<td>Has SSA award letter.</td>
<td>No Referral</td>
</tr>
<tr>
<td>5. Approved</td>
<td>Has SSA award letter - needs retro Medi-Cal.</td>
<td>DDSD</td>
</tr>
<tr>
<td>6. Denied</td>
<td>Decision on appeal. <strong>Note:</strong> No time limit nor medical conditions considered.</td>
<td>SSA</td>
</tr>
<tr>
<td>7. Denied</td>
<td>Has SSA denial letter based on income/resources.</td>
<td>DDSD</td>
</tr>
<tr>
<td>8. Denied</td>
<td>Denial within previous 60 days. Did not ask SSA to reconsider.</td>
<td>SSA</td>
</tr>
</tbody>
</table>

**Reminder:**
When DDSD is denied, evaluate other program linkage.

### 27.9.1 SSA/DDSD-SP Client Referral Chart

<table>
<thead>
<tr>
<th>If the client...</th>
<th>And the client...</th>
<th>Then the EW must...</th>
</tr>
</thead>
<tbody>
<tr>
<td>Has been denied RSDI or SSI,</td>
<td>Has received a Social Security notice of refusal to reconsider or reopen the claim,</td>
<td>Complete a DDSD referral. A copy of the notice or other documentation must be attached to the DDSD referral packet.</td>
</tr>
<tr>
<td>• Within the past 12 months, OR</td>
<td>• More than 12 months ago,</td>
<td></td>
</tr>
<tr>
<td>Has been denied RSDI or SSI</td>
<td>Has an SSA appeal pending</td>
<td>Do not refer the client to DDSD, regardless of whether or not the condition has worsened, even if the condition now meets the PD criteria. Deny the Medi-Cal application. Denial must be rescinded if SSA subsequently approves the disability claim.</td>
</tr>
</tbody>
</table>
27.10 Other Linkage

EWs must continue to process the application if other linkage exists (for example, AFDC-MN or MI). Clients in these situations who have been denied SSA disability in the past 12 months and claim a worsening or change in their medical condition should be referred back to SSA, as there are greater income deductions under ABD-MN. If there is no other linkage, deny the disability-based Medi-Cal application.

27.11 Presumptive Eligibility (PD)

Clients with medical conditions that meet the presumptive disability criteria must still be screened to determine if a DDSD referral should be completed. They are not exempt from the DDSD referral limitations. Clients with a Social Security disability or SSI denial within the past 12 months with a worsened or changed condition must be referred back to SSA.
Note:
The State must use the same PD criteria as the Social Security Administration.

27.12 Deceased DDSD Applicants

It is NOT assumed, because an applicant dies, that the disability caused the death.

EWs must follow all regular DDSD procedures:

- When retroactive onset date of disability is not requested and appropriate documentation of death (e.g., death certificate) is available, submit a limited disability referral packet.

- When a retroactive onset date of disability is requested, a full disability packet must be submitted as the onset date of disability cannot be established based on the death certificate alone.

- Write “Applicant Deceased” on the signature line of the MC 223 (for over age 18) or MC 223C (for under age 18). The Representative is to complete the application. If there is no representative, or the representative fails or refuses to cooperate, the EW conducts a “diligent search.”

- If death certificate is not available, MC 220s signed by the appropriate legal representative (spouse, legal guardian, conservator, next of kin, or the EW) should be included in the referral packet.

27.13 Determining Substantial Gainful Activity (SGA)

27.13.1 Background/Definition

Section 435.540 of the Code of Federal Regulations (42 CFR) requires Medi-Cal to use the 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.”

SGA means work that:

• Involves doing significant and productive physical or mental duties; and
• Is done, or intended, for pay or profit.

Note:
A client who performs SGA is NOT considered disabled, even if a severe
physical or mental impairment exists. However, the client may apply for the
250% Working Disabled Program.

27.13.2 When to Apply SGA Procedures

An SGA determination must only be made at the time the client applies for
Medi-Cal disability (a DDSD referral is being initiated either in intake or continuing)
and states that he/she:

• Is working, and

• Has gross earnings in excess of the allowable SGA amount. [“Substantial
Gainful Activity (SGA) Chart,” page 5-41.]

Exception:
SGA does not apply when determining eligibility for the 250% Working
Disabled Program. [Refer to “250% Working Disabled (WD) Program,” page
44-1]

27.13.3 Presumptive Disability and SGA

An applicant who performs SGA is NOT considered disabled, even if a severe
physical or mental impairment exists. This rule applies to persons who might
otherwise meet “presumptive disability” criteria.

Example:
An applicant with HIV meets the presumptive disability criteria. He is still
working and earns $3,000 gross per month. He is not considered to be
disabled under SGA. However, the next step is to explore eligibility for the
250% Working Disabled Program (WDP). This client’s earnings will meet the
income limit for the 250% WDP and will be eligible for the program assuming
that the other eligibility requirements have been met.
27.13.4 Retroactive Medi-Cal and SGA

SGA determinations also apply to requests for retroactive Medi-Cal. For example, a client applies for Medi-Cal on May 8th as a disabled person with no other linkage. She is no longer working. She has medical expenses in March and April and is requesting retroactive coverage. She was employed in the retroactive months. The EW must complete a SGA determination.

- If her net countable earnings exceed the corresponding SGA amount in each retro month, the retroactive application must be denied, and
- The current application would be processed. A DDSD referral packet for May and continuing must be initiated.

27.13.5 SGA Does Not Apply

SGA does NOT apply to:

- A Medi-Cal applicant who has received earned income within the month but is no longer working as a result of his/her disability.

Example:
A client comes in to apply on 3/4/01. He has medical expenses during the months of 1/01 and 2/01 and is requesting retro Medi-Cal for that time period. The client had been working but stopped on 2/28/01 due to a heart attack. He had gross earnings in excess of $740 (SGA in 2001) in both 1/01 and 2/01. The EW must apply SGA procedures when determining eligibility in 1/01. The client's net countable earnings exceed $740 in 1/01, therefore, retro for 1/01 must be denied. SGA does not apply to 2/01 because the client stopped working on 2/28/01. A DDSD packet and referral would be completed indicating an onset date of 2/01.

- Blind persons or persons who return to work after disability has been approved.

Exception:
If an SGA determination was not done because the client alleged blindness, then DDSD determines that the client is disabled but not blind, an SGA determination must be made before Medi-Cal based on disability is approved.

- Working disabled persons applying for the 250% Working Disabled Program.
27.13.6 Income In-Kind and SGA

For SGA determinations, Income In-Kind is considered EARNED INCOME. Earned Income In-Kind includes the value of food, shelter, or other items provided instead of cash. If food, and/or shelter is NOT a condition of employment, the lesser value of either the chart value or current market value of these items will count as wages (earned income). This amount will be considered in the SGA determination. [Refer to “Nonexempt Earned Income,” page 56-1]

Example:
Mrs. B. manages an apartment complex. In addition to her salary of $800 per month, she receives free use of an apartment where she lives. It is verified by the owner of the apartment complex that he furnishes the apartment to Mrs. B. so that she will be available for emergencies. The owner would also expect Mrs. B. to respond to emergencies during her off-duty hours and states that Mrs. B. is NOT required to live in the apartment provided, but would not have hired someone who lived more than two miles away. Similar apartments to Mrs. B’s rent for $500 per month.

Since the shelter is not a condition of employment, the lesser value of either the chart value or current market value of the shelter is considered as earned income. In the previous example, the “SGA Worksheet” (MC 272) must be completed with the amount of $153 ($153 chart value of housing for one vs. $500 market value) used as the earned income in-kind value under number one. Therefore, $800 would be entered as monthly earnings plus another $153 as income in-kind. If the total of these two incomes, less any IRWEs, is more than the current SGA amount, the individual is considered to be engaging in SGA.

27.13.7 Procedures

Apply these procedures when Medi-Cal applicants allege disability and they are working and declare gross earned income over the SGA allowance:

<table>
<thead>
<tr>
<th>STEP</th>
<th>ACTION</th>
</tr>
</thead>
</table>
| 1.   | Obtain the gross monthly earnings.  
      | • Follow existing income rules if earnings are fluctuating or irregular.  
      | • Do not count any unearned income when determining SGA.  
      | • If earnings are from self-employment, deduct the business expenses prior to deducting any IRWE. |
| 2.   | Give the client the “Work Activity Report” (MC 273) for completion to identify all possible Impairment-Related Work Expenses (IRWE) and work subsidies which may be deducted from gross earnings. |
27.13.8 Impairment-Related Work Expenses (IRWEs)

Conditions

Impairment-Related Work Expenses (IRWEs) are certain expenses which are incurred and paid by a disabled client which enable him/her to work. IRWEs are an allowable deduction from earned income when determining SGA. Deductions are allowed when the following conditions exist:

• The disabled client needs the item/service in order to work. (The need must be verified by a statement from the prescribing source, e.g., doctor, Vocational Rehabilitation counselor.)

• The cost is paid by the client and not reimbursed by another source. The cost must be paid in cash, including checks or money orders, and NOT in-kind. The cost must be verified.

Note:
At the point of application, when Medi-Cal has not yet been approved, medical expenses (i.e., prescriptions) can be allowed as an IRWE deduction even if Medi-Cal will cover these expenses later.
• The expense must be “reasonable” (comparable to the charge for the item/service in the community).

MC 272

The “SGA Worksheet” (MC 272) may be used to compute the client’s earnings and IRWE/Subsidy deductions as follows:

• Net earnings are at the level of current SGA amount or less: process the application in the usual manner.

• Net earnings are more than the current SGA amount per month: deny application as the client is engaging in SGA.

• Whenever the net countable earnings are less than the current SGA amount per month and the EW determines that there is no SGA issue, a copy of the MC 272 must be included in the disability packet. Item 10 of the MC 221 must indicate that there is “NO SGA ISSUE.”

MC 273

The “Work Activity Report” (MC 273) is given to the client to assist in determining if he/she has any impairment-related work expenses or work subsidies that can be deducted from gross earnings.

• Do not deny the application if the client chooses not to complete or return the MC 273.

• Determine SGA based on earnings and any IRWE that is verified.

Budgeting IRWE

IRWEs can be deducted from gross earnings to arrive at net countable earnings:

<table>
<thead>
<tr>
<th>If the net countable earnings are...</th>
<th>Then the EW must...</th>
</tr>
</thead>
<tbody>
<tr>
<td>Under the SGA amount,</td>
<td>Continue processing the Medi-Cal application (i.e., submit a disability packet to DDSD).</td>
</tr>
<tr>
<td>Over the SGA amount,</td>
<td>Deny the application and explore eligibility under other Medi-Cal programs, i.e. 250% Working Disabled Program.</td>
</tr>
</tbody>
</table>

NOTE: For self-employment, IRWEs can be deducted from net income, if not already deducted from gross earnings as a business expense.
Example:
The SGA is $780, and the client earns $1,000 per month and has $200 worth of IRWEs for special transportation costs to go to work and for medications needed to control a seizure condition. In this example, the net countable earnings are $800 per month. As net countable earnings are $800 per month, the client is performing SGA and the application is denied.

Payment must be made after the client became disabled in order to allow the cost as a deduction. Payment is computed in the following ways:

**Recurring costs** The actual amount paid is allowed as a monthly deduction (e.g., the monthly payments for a wheelchair).

**Non-Recurring costs** If the full purchase price of an item or a non-recurring down payment has been paid, the expense may be prorated over a 12 month period beginning with the month of purchase.

Example:
An employed disabled individual purchases a new wheelchair for $1200 in December. She subsequently applies for Medi-Cal in March of the following year. The prorated monthly cost, $100, is allowed when determining SGA.

**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.

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

### 27.13.9 Types of IRWE

**Attendant Care**

Attendant care is deductible if provided in a work setting or when assisting in preparation for and after work (e.g., bathing, dressing, meal preparation). The cost must be paid in cash, not in-kind. It requires verification of duties, amount of time spent, payment was made in cash, and that payment is made on a regular basis.

Attendant care is not deductible if the service is performed by a family member and the family member has not terminated or reduced his/her employment in order to provide attendant care services. Non-workday attendant care services or general
homemaking services (shopping, cleaning, baby-sitting, etc.) are not allowable. Services performed by a family member for cash fee where the family member suffers no economic loss are not deductible.

**Transportation Costs**

The cost of a vehicle is NOT allowed, whether modified or not. Modifications that are not directly related to the impairment are not allowed. Medical and other transportation expenses are not allowed. Structural or operational modifications to the vehicle are deductible if it is used to drive to work (or used to be driven to work), even if also used for non-work purposes. Mileage to and from work and the costs of a taxi or driver assistance are also allowable expenses.

**Note:**

Use the current county mileage reimbursement rate for employees to compute the cost of mileage to and from work when the individual uses his/her own vehicle, unless actual costs are higher and can be verified.

**Medical Devices**

Allow the cost of any device used for a medical purpose (e.g., wheelchair, braces, hemodialysis equipment, pacemakers, respirators, traction equipment, braces for arm/leg/neck or back, etc.).

**Prosthesis**

Artificial hip and artificial replacement of an arm, leg or other part of the body are allowable. Any prosthetic device that is primarily for cosmetic purposes is not deductible.

**Work-Related Equipment and Assistants**

Any special work-related device (i.e., one-handed typewriters, typing aids, etc.), special tools (i.e., electronic visual aid, telecommunications devices, etc.), special assistants (such as an interpreter for the hearing impaired) may be allowed:

- If required due to the impairment and it is not paid for by another source, such as Vocational Rehabilitation,

- If the individual is self-employed, the cost of equipment previously deducted as a business expense cannot be allowed.
Residential Modifications

If the client is self-employed at home, any modifications to the home made to accommodate the impairment may be allowed unless previously deducted as a business expense.

If the client is employed outside of the home, only modifications to the exterior of the home to allow access to the street or to other transportation are allowed (e.g., ramps, exterior railings, pathways, etc.).

If the individual is self-employed at home, modifications made inside the home to accommodate the impairment are allowed (i.e., enlargement of a doorway leading into an office, etc.)

Drugs, Medical Services, Diagnostic Procedures, and Medical Supplies

Any items that are necessary to control the disabling condition are deductible. Regularly prescribed medical treatment or therapy that is necessary to control a disabling condition, such as anti-convulsant drugs or blood level monitoring, radiation treatment or chemotherapy, corrective surgery for spinal disorders, antidepressant medication, electroencephalograms, brain scans, etc. The physician’s fee relating to these services is deductible.

Non-Medical Appliances/Devices

In unusual circumstances, a non-medical appliance/device may be allowed if it is essential to control the disabling condition either at home or in the work place (i.e., an air cleaner for a client with a severe respiratory disease). The need must be verified by a physician.

Other Items and Services

Medical supplies of an expendable nature are deductible (i.e., incontinence pads, elastic stockings, catheters, etc.). The cost of a guide dog, including food, licenses, and veterinary services are allowed.

27.13.10 Work Subsidies

“Work Subsidy” is the monetary support an individual receives on the job which could result in more pay than the actual value of the service performed. An employer may, because of a benevolent attitude toward a disabled individual,
subsidize the employee’s earnings by paying more wages than the reasonable value of the actual services performed. When this occurs, the excess will be regarded as a subsidy.

Subsidies are deducted from gross earnings to arrive at the net countable earnings for SGA eligibility determinations. Subsidies are not considered an earned income exemption for budget determinations, once a medical determination is made. These subsidies are considered UNEARNED INCOME.

**Subsidies:**

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

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

- 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. They are considered unearned income.

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

**Example:**

A working disabled individual earns $800 per month. The employer states that the actual value of the client's work is half the value of actual earnings. The clients earns $800 per month. As half the work is subsidized, $400 is considered the real value of work and the client is not engaging in SGA. The $800 is the non-exempt income for the EW to use when computing the client's budget.

**27.13.11 Medi-Cal Budget**

Deductions for Impairment-Related Work Expenses (IRWE) and work subsidies are only allowed when determining Substantial Gainful Activity (SGA). Do not apply IRWEs or deductions for work subsidies to the Medi-Cal budget once Medi-Cal has been approved.
27.13.12 Unsuccessful Work Attempt (UWA)

If a client is forced to stop working after returning to work for a short time, that work is generally considered an Unsuccessful Work Attempt (UWA). Earnings from that job will not be used to show an ability to do SGA.

All the following must be present for work to be considered UWA:

• There is a break in the client’s employment of 30 days or more, and
• Work lasted less than six months, and
• Work stopped due to client's impairments.

Example:
Client worked from December 1st to June 30th. Work stopped due to his impairment. He returned to work on 8/5 and stopped again on 9/1. He applied for Medi-Cal on 9/2 and requested retro back to July.

EW's Analysis

• Break in employment of over 30 days from 6/30 to 8/5.
• Work lasted less than six months from 8/5 to 9/1.
• Work stopped due to client's impairment.

EW's Actions

• In Item 10 of MC 221, indicate "work after 6/00 is UWA."
• In Item 6 of MC 221, list retro months of July and August.

27.13.13 Example of an SGA Determination

Mr. Thomas is employed despite his HIV condition. He earns $1,200 gross per month, effective January 1st. He is currently paying $800/month for medications. There are no other IRWEs.

Gross Earnings $1,200
- IRWE - 800 (cost of medication)

Net Earnings $  400

Since Mr. Thomas' net earnings are less than the SGA amount of $860 per month, he is NOT performing SGA. The EW must include a copy of the “SGA Worksheet” (MC 272) in the DDSD packet and indicate “No SGA Issue” on Item 10 of the MC 221.
27.14 Disability Referral Checklist

Counties who have a high volume of returned disability packets due to inappropriate or incomplete referrals, or incorrect usage of obsolete forms are subject to corrective action measures. Below are reminders to address some of the error prone areas:

- Check for prior SSA or DDSD decisions (available in the case/system) that are still currently in effect prior to sending disability referrals.
- The latest revision of the “Authorization for Release of Medical Information” (MC 220).
- Invalid or pseudo Social Security Numbers (SSN) must not be used. If the client has no SSN, check the applicable box (pending or none) on Item 2 of the MC 221.
- Ensure that pertinent case/county information is complete and correct.
- Ensure that all required forms are completed and properly signed. The MC 220 must be witnessed if the individual authorizing the release of information signs with a mark, or the signature is illegible, or signed in foreign characters. [See “Authorization for Release of Information” (MC 220),” page 29-3 for detail].
- The “Date Applied” (Item 5 of the MC 221) is the date the individual applied as a disabled person and not necessarily the date of application (per SAWS 1). It is important that the “Date Applied” entered is correct because it is the beginning date for the 90-day promptness requirement. Also, any dates earlier than the date needed to have disability linkage results in unnecessary disability determination for DDSD.

Example 1: A mother and child apply for Medi-Cal on 4/1/04. There is AFDC-MN linkage and no share of cost in April. The mother claims disability in 5/15/04. The EW must use 5/15/04 in Item 5 of the MC 221. Document on CaWIN [Maintain Case Comments] window the date the mother claims disability.

Example 2: Same situation above except that retro Medi-Cal is requested for 3/04. The intake EW must use 5/15/04 in Item 5 and enter 3/04 in Item 6 “List retro month(s)” of the MC 221.
• Limit the request for disability determination for a retroactive onset date sufficient to cover only the number of retro months requested by the applicant. For example, some applicants/beneficiaries may only request one or two months of retroactive coverage.

• Ensure that all medical sources are listed for the requested period, including packets with death certificates.

• To obtain earlier onset dates on a case with a prior DDSD decision, submit a copy of the prior decision (or MC 221) with a notation in Item 10 of the MC 221 that a "retro onset date is needed."

• A limited packet may be sent to request a copy of a prior DDSD decision. Item 10 of the MC 221 should be annotated that “a copy of a prior DDSD decision is being requested.”

• A limited packet may be sent if the reexam date is unknown or not available. Annotate in Item 10 of the MC 221 the purpose of the limited packet.

• Mail three copies of the MC 221. One copy is mailed back to the county after DDSD finishes processing the case and others are needed by DDSD for their records.

• If an applicant provides an SSA (Title II) award letter, a disability referral is not necessary.

• A “90-Day Status Letter” (MC 179) must be sent by the EW to the client when a DDSD packet has not been forwarded to DDSD by the 80th day from the date of the disability-based application.

• When determining disability for a child instead of completing the MC223, complete the MC 223C. Part 4 of the MC 223C includes the name and address of all schools the child has attended, all services the child is receiving (e.g., special education, speech/language therapy, special accommodations, etc.). Names and telephone numbers of the child’s Social Worker, Psychologist or Speech Pathologist and Individual Education Plan (IEA) should also be included, if available. IEA is completed by the school wherein the teachers assess a child’s functioning for the school year.
27.15 DDSD — Providing EW Observations

Because EWs may have direct client contact they are in a good position to provide valuable information to DDSD regarding the physical and/or mental disability status of Medi-Cal applicants. The EW can assist DDSD by identifying conditions that the client did not mention or by expanding on information provided by the client.

27.16 Use of MC 221 or DHS 7045

EWs may record observations about medical conditions in the County Worker Comment(s) section of the “Disability Determination and Transmittal” (MC 221) or on the optional form, “Worker Observations-Disability” (DHS 7045).

The DHS 7045 can be sent with the DDSD packet or at a later date, should the EW have additional observations to provide.

Unusual behaviors which suggest mental conditions should be noted, as they are frequently not admitted to by the client and because they may severely restrict the client's ability to work. Additionally, a client may identify only the physical impairment he/she considers disabling and may neglect to mention other impairments which may be contributing to the disability.

In no case will worker comments adversely affect a disability evaluation. EW comments are used to identify impairments which the client may not have reported.

27.17 Guidelines for Observations

27.17.1 General

This information is only for reference; it is not all-inclusive. The EW should be sensitive to the type of disability claimed and use common sense in the type of observations made. Any indication that the disability may be other than the alleged one(s) should be reported.
27.17.2 Physical Mobility

- Difficulty walking, standing, and sitting or need for another person's assistance in doing these.
- Use of mobility devices such as wheelchair, braces, cane, or 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:
The 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 of time.

27.17.3 Physical Appearance

- Height and weight, or a significant, recent change in weight. Unusually thin, overweight, short, tall, malnourished appearance, etc.
- Unusual skin conditions such as scaling, peeling, unusual color, scarring with signs of disfigurement or deformity.
- Absence of any extremities, use of a prosthetic device.

Example:
The 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.

27.17.4 Other Physical Problems

- Breathing difficulties, such as frequent coughing or rapid breathing.
- The appearance that drugs, alcohol, or medication may be affecting the client's physical/mental functioning.
Example:
The client coughed frequently throughout the interview. When asked if she had a cold, she said, “No, I just cough a lot in the morning”.

27.17.5 Special Senses

- Problems with hearing, use of a hearing aid, reliance on another person 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 not wearing a hearing aid and was able to answer questions without any difficulty hearing me.

27.17.6 Mental and Emotional Status

- Disoriented, does not know his/her name, date and/or time, where he/she is or the reason for the interview.
- Has difficulty understanding things which is not due to a language barrier. Has a limited attention span and/or a poor memory.
- Conversation is repetitive or wandering and/or 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, or inappropriate dress.

Example:
The client arrived for her appointment at the correct time but on the 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.

In addition to checking the appropriate boxes on the “Worker Observations - Disability” (DHS 7045) form, the EW documents on the “Remarks” section “The client walks slowly and he drags his right foot. He seems quite nervous and appears to have a very short attention span. His wife conducted most of the interview, and at times it appeared that the client wasn’t paying any attention to what was going on around him.”

27.18 DDSD — Disability Evaluation Forms

Disability referrals are initiated by sending a disability evaluation packet to the State Programs - Disability Determination Service Division (DDSD). The packet contains forms completed by the client or the EW. DDSD uses these forms and other information to make an evaluation.

• DDSD returns a copy of the MC 221 and results of the evaluation to the EW.

• For those applicants found not disabled, DDSD will send a notice that must be enclosed with the county’s Notice of Action which will explain the basis for the denial of disability. (Also scan a copy of the notice in the IDM system.)

27.19 Forms/Documents to be Included in the DDSD Packet

27.19.1 List of Forms

The following forms must be used when making referrals to DDSD, unless otherwise indicated:

<table>
<thead>
<tr>
<th>Form</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>MC 017</td>
<td>What You Should Know About Your Medi-Cal Disability Application (Given to client at the interview or mailed if it’s a mail-in application).</td>
</tr>
<tr>
<td>MC 179*</td>
<td>90-Day Status Letter Must be sent when the DDSD packet has not been forwarded to DDSD by the 80th day from the date of the disability-based application.</td>
</tr>
</tbody>
</table>


27.19.2 List of Documents

Medical Records

If the client’s medical records are readily available, copies may be included with the above forms and sent to DDSD. However, in no case should the DDSD referral be held up pending receipt of such medical records. The DDSD packet must be sent no later than ten days after the MC 210 form or other applicant/beneficiary’s statement of disability is received. If medical records are received later, send them to DDSD with an MC 222.

SSA Documents

Send copies of a Social Security Administration (SSA) Disability approval or denial with the above forms, if applicable. If the SSA Disability approval/denial notice is received later, forward it to DDSD with an MC 222.
Death Certificate

Send the death certificate, if applicable. If it is received later, send it to DDSD with an MC 222.

27.20 “What You Should Know About Your Medi-Cal Disability Application” (MC 017)

27.20.1 Purpose

This is an optional form which may be given to a client who wishes to apply for Medi-Cal as a disabled person. This informational form gives the client an overview of what happens during the application process.

27.21 “90-Day Status Letter” (MC 179)

27.21.1 Purpose

The Radcliffe v. Coye, et al lawsuit requires that notification be sent to the client when a disability decision will not be reached within 90 days. For new applicants, the 90 days begin from the date of application (usually the date on the SAWS 1). For continuing recipients, the 90 days begin on the date that the client informs the EW that he/she is disabled. [Refer to “Delayed DDSD Referrals,” page 30-2 for additional information.]
27.22 “Authorization for Release of Information” (MC 220)

27.22.1 Purpose

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. It also authorizes the release of information other than medical records (e.g., education records). The form is designed to provide all the items that providers must have in an authorization before they are permitted to disclose protected health information. The MC 220 is printed in English and Spanish.

27.22.2 How Many?

A signed and dated MC 220 is required for EACH treatment source (one who has treated the client for a significant medical problem), testing facility, or agency listed on the MC 223 or MC 223C, except for the Social Security Administration.

27.22.3 Completion Requirements

Appropriate Actions

• Enter the client's name, valid Social Security Number, and date of birth.

• Ask the client to sign and date the MC 220's. Once dated, the forms are valid for one year from the date signed.

Inappropriate Actions

• Do NOT alter, cross out, white out, or make changes to an MC 220, as these changes are not acceptable to the treatment source. DDSD will return an MC 220 that has been altered.

27.22.4 Signature Requirements

The MC 220 may be signed by the:
• Client

Reminder:
Client’s signature MUST be legible. Hospital medical records will not be available to DDSD by the medical providers if they cannot read the client’s signature. [See “Exceptions/Special Situations” below for more information]

• Legal representative of a minor or incompetent client
• Legal representative of a client who is physically incapable of signing
• Legal representative of an incompetent or deceased client.
• Legal guardian, conservator, or EW may sign.
• An authorized representative other than those listed may not sign the MC 220.

Note:
If someone, other than the client signs the MC 220, he/she must sign their own name with the explanation underneath the signature.

Note:
When requesting medical information pertaining to minor consent services, the minor (who is age 12 or older) must sign the MC 220, and the “Minor Consent Services Only” box must be checked.

Exceptions/Special Situations

These rules apply when someone other than the client must sign the MC 220:

<table>
<thead>
<tr>
<th>If the client...</th>
<th>Then the MC 220...</th>
</tr>
</thead>
<tbody>
<tr>
<td>Has a guardian or conservator,</td>
<td>Must include the signature of guardian or conservator and the relationship to client must be checked and/or entered (e.g., legal guardian). Note: Minors age 12 and older must sign a release. In addition, the parent or guardian of every minor must sign a separate release except in those cases involving Minor Consent only.</td>
</tr>
</tbody>
</table>
A person representing or assisting a competent applicant/beneficiary may not be given information about the client unless a signed statement authorizing such actions or an “Appointment of Representative” (MC 306) is included in the DDSD packet.

### 27.22.5 Reminders

- Applicants should sign their own releases whenever possible. Providers are not obligated to accept a medical release signed by an authorized representative.

- If the individual is a competent adult and is physically capable of signing his/her own medical releases, no other person, including a spouse, may legally release that individual's medical records.

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

<table>
<thead>
<tr>
<th>If the client...</th>
<th>Then the MC 220...</th>
</tr>
</thead>
</table>
| Is incompetent or physically incapable of signing. | May be signed by the legal or personal representative who is acting on the client's behalf if there is no guardian or conservator.  
  - Enter the relationship to the client next to signature (e.g., spouse, mother.).  
  - State the reason why the client cannot sign the MC 220 below the signature line. |
| Can only sign with a mark (e.g., “X”), or the signature is not legible, or other non-English character (i.e., Chinese, Arabic), | Must include the:  
  - Signature or mark of client.  
  - Client’s name, written next to the “X,” symbol, or illegible signature  
  - Signature of a witness and date signed. (Witness signatures with an "X," symbol, or other illegible signatures are not acceptable.)  
  - Relationship of witness to client.  
  - Complete address of the witness  
  NOTE: The EW may sign as a witness. |
27.22.6 Revocation

The client may revoke and/or modify the authorization at anytime, except for actions already taken. To revoke an authorization, the client must:

- Send a written statement to:

  State Programs - Disability and Adult Programs Division
  Attention: Professional Relations Specialist
  P.O. Box 23645
  Oakland, CA. 94623-0645

- Send a copy of the revocation request to any sources that the client no longer wants his/her information disclosed.

27.23 “Disability Determination and Transmittal” (MC 221)

The MC 221 is the transmittal and disability determination document shared between the EW and DDSD. It is used for new DDSD referrals or for resubmitted cases.

Note:
Use the “DDSD Pending Information Update” (MC 222) to send changes or additional information on pending DDSD cases. [Refer to “DDSD Pending Information Update” (MC 222),” page 27-42] and [Refer to “Reporting Changes to DDSD,” page 30-4] for additional information.

27.23.1 Completion Requirements

Items 1-4 and 7

Provides identifying information about the applicant. Enter all information.
Item 2

DDSD files all disability records by the client's social security number (SSN); therefore, the valid SSN must be included on the MC 221 whenever it is available. If there is no SSN, then the EW must indicate this by checking the applicable box.

Check the “Pending” box if the client has applied for a SSN and the status is pending; check “None” if the applicant is undocumented with no SSN. Do not enter an invalid or pseudo SSN.

Item 5

The month, day and year that the client applied must be provided as follows:

- For a new Medi-Cal applicant, enter the date that the SAWS 1 was signed.
- For a recipient who alleges blindness or disability, enter the date that the client's disability was first reported to the EW.

The “Date Applied” is important because it is the beginning date for the 90-day promptness requirement.

Item 6

List each separate month for which retroactive coverage is requested (not to exceed more than 3 months prior to the “Date Applied”).

Item 8

Check all applicable boxes. (Definitions of all terms listed in Item 8 are included on the back of the MC 221 for easy reference.)

Item 9

Check if the client is currently in the hospital and identify the hospital. If checked, include an MC 220 for the hospital.

Item 10

Enter any information that you wish to relay to DDSD, such as comments about the client's condition/appearance.
• If there is insufficient room to explain, comments can be made on a separate sheet and mailed with the packet. Check the “See Attached Sheet” box. Or, the DHCS 7045 may be sent.

• Indicate if client is applying for the 250% Working Disabled program and SGA does not apply, if appropriate.

• Check the “90-Day Status Letter Attached” (MC 179) box if it is included because the packet is being mailed more than 80 days from the “Date Applied”.

• Check the “Presumptive Disability Approved” box if applicable.

• This section can also be used for other information about the applicant (e.g., other names used, clarification of SSN, need for expeditious handling, dates of prior MN, SSI, or RSDI applications or benefit periods, contact with state rehabilitation and other service agencies, etc.)

**Items 11, 12**

Clearly enter worker number, name, phone number and the date the packet is being sent.

**Items 13-20**

These items will be reserved for DDSD. DDSD will attach a separate document “DDSD Disability Determination - Response to MC 221” (SP2 DDSD 221R) if disability is approved, denied, or if no determination was made. [Refer to “DDSD — EW Procedures,” page 30-1 for information about DDSD disability decisions and codes.] Do not mail the response to the client.

### 27.24 “DDSD Pending Information Update” (MC 222)

#### 27.24.1 Purpose

The MC 222 is sent to DDSD when the EW becomes aware of new or changed information affecting a pending case.
27.24.2 Types of Changes to Report

The EW must use the MC 222 to report the following types of changes to DDSD:

- Change in client's address,
- Change in client's name, telephone number or message number,
- Denial or discontinuance of client due to non-medical information (e.g., excess property),
- Withdrawal of application,
- Death of client,
- Receipt of new medical evidence (attach new medical evidence to MC 222), or
- Any other pertinent information which affects DDSD's actions on a pending case.

[Refer to “Reporting Changes to DDSD,” page 30-4 for additional information.]

27.25 “Applicant's Supplemental Statement of Facts for Medi-Cal” (MC 223)

27.25.1 Purpose

The MC 223 helps DDSD obtain a clear and accurate picture of the client's disabling condition(s). The client is requested to identify all pertinent medical, vocational, social and/or third party sources who can provide relevant information regarding his/her condition. Addresses and telephone numbers of each source must be provided.

27.25.2 Impact of Prior SSA Decision

The 1990 revisions to 42 CFR 435.541 clarify that a prior SSA disability decision determines whether the client must be referred back to SSA, or be allowed to file a Medi-Cal disability application.

It is extremely important that the client informs the EW of any SSA disability decision, including prior, pending and appealed claims. Questions 5 - 5d are intended to help the EW determine whether to deny the DDSD application and refer the client back to SSA or to initiate a DDSD referral. [Refer to “DDSD — Disability Referral Criteria,” page 27-1].
The MC 223 is designed for completion by the applicant, not the EW; however, the EW should assist as needed.

27.25.3 Completion Requirements: Part I — Personal Information

Item 1a
Client’s full name.

Item 1b
The client’s social security number must be entered. This space must not be left blank; e.g., check “Pending” or “None”, as appropriate.

Item 1c
Client’s complete date of birth (including year).

Item 1d
Enter all known aliases. (This information can be very useful as sometimes medical records are under a different name.)

Item 1e
Specify sex.

Items 1f-1g
Enter height in feet and inches and weight in pounds. (This can be vital information when evaluating certain disabilities.)

Items 2a-2b
The home address (or residence where correspondence can be mailed) must be listed.
Item 3

Enter area code and phone number. Indicate if there is no phone or if there is a message number. (Also indicate if there is a best time to call during normal working hours.)

Item 4a-4b

If the client does not speak English, it is important that an interpreter’s name and telephone number are listed.

27.25.4 Part II — Medical Information

Item 5a - 5d

Indicate if the client applied for Social Security or SSI disability benefits within the past two years. This information is used to determine if there has been a prior SSA disability decision. And, if so, whether the client must be referred back to SSA or a DDSD referral initiated. [Refer to “DDSD — Disability Referral Criteria,” page 27-1 for instructions.]

Item 6

The medical conditions that prevent work activity or limit activities of daily living must be listed. Include treated and untreated conditions and attach additional pages if needed.

Items 7-8

Enter the names, addresses (including ZIP codes), current phone numbers (including area codes), and patient/clinic/member numbers (if applicable) of any hospital or clinic where treatment was received in the last 12 months.

DO NOT LEAVE THE ADDRESS BLANK.

If the client is unable to provide the address, the EW must make an effort to find the address. If the information cannot be found, this must be stated on the address line or indicated in the county use margin so that DDSD will know that it was not inadvertently omitted.

If the client has been seen at additional clinics or hospitals, complete page 8.
Reminder:
An MC 220 must be completed for each treating source listed on the MC 223. (Check boxes are added to the county use margin to remind EWs that an MC 220 is needed.)

Item 9
Any doctors seen outside of the hospital(s) or clinic(s) listed in items 7 or 8 in the last 12 months must be listed here. Enter complete names, addresses (including ZIP codes), and current phone numbers (including area codes).

If the client is unable to provide the address and the EW has made an effort to find the address but the information could not be located, this must be stated on the address line or indicated in the county use margin so that DDSD will know that it was not inadvertently omitted.

If the client has been seen by additional doctors, complete page 8.

An MC 220 must be completed for each treating source listed on the MC 223.

Item 10
All tests performed in the last 12 months must be listed.

• If the purpose or the name of the test is unknown, enter “Unknown test” in “Other” and enter the name and address of the test facility and date.

• If there is no space to list all tests, enter additional testing information at the bottom of page 8.

Reminder:
An MC 220 must be completed for each treating source listed on the MC 223.

Item 11
If client has had additional medical treatment in the past 12 months, enter the information on page 8.

Item 12
Third party sources who know about the client’s medical condition should be listed. They will be contacted if DDSD needs to clarify the client’s functional ability.
Item 13

A client may be required to go to additional medical examinations which is scheduled and paid for by DDSD. The client must indicate whether he/she is willing to go to the exams if needed.

27.25.5 Part III — Social and Educational Information

Item 14

The client is to describe his/her day-to-day activities and how those activities are affected by the client’s condition(s). This helps DDSD to determine the extent of the disabling condition and it’s effect(s) on the client’s ability to function, especially in mental or emotional disorders.

For example, household maintenance activities, walking, driving, recreation should be considered.

Item 15a - 15c

Indicate the highest grade completed or if a GED was obtained, when it was completed, or if special education classes were involved.

If the client states that he/she does not know what level of education was completed or information is not available, the EW should note this in the right margin. DO NOT LEAVE THIS SECTION BLANK.

Note:
If there are inconsistencies (i.e., the client indicates that he/she completed high school but has significant difficulties reading, writing, or understanding), inform DDSD by making comments in the margin of the MC 223, in the comments section of the MC 221, or by using the DHCS 7045.

Item 16

Indicate if there was employment within the past 15 years. This includes work which was performed outside of the United States. If work was performed during the past 15 years, the client must complete Part IV.
27.25.6 Part IV — Work History

Item 17a - 17b

Job titles and the dates worked, including jobs performed outside of the United States, are to be entered. Describe the job, as the actual work performed may differ from what is described in the “Dictionary of Occupational Titles (DOT)” which lists jobs performed in the national economy. DDSD will use the DOT job description if the client does not provide a job description.

If more than two jobs were performed in the last 15 years, give the client extra copies of the MC 223, “Part IV - Work History” section to complete.

Important:

Remember that DDSD is looking for the type of work performed, not the number of various employers that the client has had. For example, if the client is a machinist and he has had three different employers over the past 15 years, then only one work history form must be completed.

Guidelines for what to include in the job description:

- Types of tools, machines or equipment used.
- Was writing involved?
- Were there supervisory duties?
- Frequency and amount of lifting required in the job.
- Hours spent sitting, standing and walking.
- Other activities requiring exertion, such as climbing or bending.
- Describe any alterations made to the job functions to accommodate impairments, such as special equipment or changes in job duties.
- Did the client's condition make it necessary to stop working and, if so, when did this occur?

27.25.7 Part V — Signature and Certification

Enter signatures and the current date.
27.26 “Supplemental Statement of Facts for Medi-Cal Child Applicant Only - Under Age of 18” (MC 223C)

27.26.1 Purpose

The MC 223C is to be used for applicants filing for Medi-Cal based on a disability, who have not yet reached their 18th birthday. The client is requested to identify all pertinent medical, vocational, social and/or third party sources who can provide relevant information regarding child’s condition. Addresses and telephone numbers of each source must be provided.

27.26.2 Impact of Prior SSA Decision

The 1990 revisions to 42 CFR 435.541 clarify that a prior SSA disability decision determines whether the client must be referred back to SSA, or be allowed to file a Medi-Cal disability application.

It is extremely important that the client informs the EW of any SSA disability decision, including prior, pending and appealed claims. Questions A-D in Part 3 are intended to help the EW determine whether to deny the DDSD application and refer the client back to SSA or to initiate a DDSD referral. [Refer to “DDSD — Disability Referral Criteria,” page 27-1].

The MC 223C is designed for completion by the child’s parent, guardian or other personal representative, not the EW; however, the EW should assist as needed.

27.26.3 Completion Requirements: Part 1 — Personal Information

Item A

Child’s full name.
Item B

The child's social security number must be entered. This space must not be left blank; e.g., check “Pending” or “None”, as appropriate.

Item C

Child's complete date of birth (including year).

Item D

Specify child's sex.

Items E-F

Enter child’s height in feet and inches and weight in pounds. (This can be vital information when evaluating certain disabilities.)

Item G

Enter name, relationship, address and the phone number including area code of the person child lives with. The home address must be listed.

Item H

Enter mailing address if different than home address.

Item I

Enter name and relationship to the child of the person applying for the child. Enter area code and phone number. Indicate if there is no phone or if there is a message number. Also indicate a name of the person to leave message with.

Item J

Indicate what language/dialect does the person applying for the child speak and read best.
27.26.4 Part 2 — The Child’s Illnesses, Injuries, or Medical Conditions

Item A

List child’s illnesses, injuries and medical conditions. Include treated and untreated conditions and attach additional pages if needed. Indicate when did it start (month/year).

27.26.5 Part 3 — Social Security/SSI Information

Items A-D

Indicate if the child applied for Social Security disability or SSI disability benefits in the last two years. This information is used to determine if there has been a prior SSA disability decision. And, if so, whether the client must be referred back to SSA or a DDSD referral initiated. [Refer to “DDSD — Disability Referral Criteria,” page 27-1 for instructions.]

27.26.6 Part 4 — Special Sources and School Information

Item A

Indicate if the child has ever been tested or evaluated by any of the listed agencies, or do any of these agencies have medical record or information about the child.

Item B

Enter the names, addresses (including ZIP codes), current phone numbers (including area codes). List all test or evaluations performed (for example, vision, hearing, speech, physical, psychological). Enter the date of the evaluation or test and child’s ID number or claim number.

Item C

Indicate if the child is or was attending any type of preschool, day care, and/or after school program. Enter the names, addresses (including ZIP codes), current phone numbers (including area codes), contact person name and dates attended.
Item D

Indicate if the child is or was attending school. Enter the names, addresses (including ZIP codes), current phone numbers (including area codes), and names of the teachers.

Item E

Indicate if the school makes any special accommodations for the child (for example: adaptive furniture, wheelchair ramps, extra assistance, or attention). Indicate what type of accommodation.

Item F

Indicate if the child is in a special education program. Enter the type of special education program.

Item G

Indicate if there is a copy of the child’s Individualized Education Plan (IEP), and provide a copy if applicable.

Item H

Indicate if the child receives any special counseling or tutoring, and if counseling or tutoring is received at school or outside the school. Enter the names, addresses (including ZIP codes), current phone numbers (including area codes), frequency of visits and dates therapy started and ended.

Item I

Indicate if the child receives any special therapy or any other services for his/her illness or injuries. Include information about any therapy the child receives from parent, guardian, caregiver or in school. Enter the names, addresses (including ZIP codes), current phone numbers (including area codes), name of the person who prescribed the therapy, type of the therapy, frequency of visits and dates therapy started and ended.
Note:
DO NOT LEAVE THE ADDRESS BLANK. If the client is unable to provide the address, the EW must make an effort to find the address. If the information cannot be found, this must be stated on the address line or indicated in the county use margin so that DDSD will know that it was not inadvertently omitted.

Reminder:
An MC 220 must be completed for each source listed on the MC 223C in Part 4, items A-I. The parent of the child, guardian or other personal representative must sign an MC 220 and appropriate box must be checked. (Check boxes are added to the county use margin to remind EWs that an MC 220 is needed.)

27.26.7 Part 5 — Medical Information

Item A

Enter the names, addresses (including ZIP codes), current phone numbers (including area codes), and hospital/clinic/file numbers (if applicable) of any hospital or clinic where the child received treatment in the last 12 months.

Item B

Any doctors seen outside of the hospital(s) or clinic(s) listed in item A in the last 12 months must be listed here. Enter complete names, addresses (including ZIP codes), and current phone numbers (including area codes).

If the child has been seen at additional clinics or hospitals, use Part 9 - Remarks (page 9).

Note:
DO NOT LEAVE THE ADDRESS BLANK. If the client is unable to provide the address, the EW must make an effort to find the address. If the information cannot be found, this must be stated on the address line or indicated in the county use margin so that DDSD will know that it was not inadvertently omitted.

Reminder:
An MC 220 must be completed for each treating source listed on the MC 223C Part 5, items A-B. The parent of the child, guardian or other personal representative must sign an MC 220 and appropriate box must be checked.
27.26.8 Part 6 — Medications

List any prescribed medications, that the child is currently taking. Include name of the prescribed medication, name of the doctor, reason for medication and side effects if any. If the child has additional prescribed medications list them in Part 9 - Remarks (page 9).

27.26.9 Part 7 — Tests

Provide information for medical tests, that the child had or will have and enter the name and address of the test facility, date, and name of the medical professional who sent the child for the test. If there is no space to list all tests, enter additional testing information in Part 9 - Remarks (page 9).

Reminder:
An MC 220 must be completed for each test facility listed on the MC 223C Part 5, items A-B. The parent of the child, guardian or other personal representative must sign an MC 220 and appropriate box must be checked.

27.26.10 Part 8 — Work History

If the child ever worked, enter the dates worked, employer name, address (including ZIP code), phone number (including area codes) and the supervisor’s name.

Reminder:
An MC 220 must be completed for each employer listed on the MC 223C. The parent of the child, guardian or other personal representative must sign an MC 220 and appropriate box must be checked.

List the child’s job title and describe the work and any problems the child may have doing the job.

27.26.11 Part 9 — Remarks

Enter any additional information relevant to previous questions if applicable.
27.26.12 Part 10 — Signature and Certification

Enter signature and the current date. Must include the signature of the parent, guardian or other personal representative and the relationship to child must be entered (e.g., parent of minor).

27.27 “SGA Worksheet” (MC 272)

This worksheet is used to determine if SGA applies when an applicant has gross earnings over the current SGA. The MC 272 may be used to compute the client’s earnings and IRWE/Subsidy deductions as follows:

- Net earnings are at the level of current SGA amount or less: process the application in the usual manner.

- Net earnings are more than the current SGA amount per month: deny claim as client is engaging in SGA.

- Whenever the gross monthly earnings are more than the current SGA amount per month and the EW determines that there is no SGA issue, a copy of the MC 272 must be included in the disability packet. Item 10 of the MC 221 must indicate that there is “NO SGA ISSUE.”

Reminder:
If SGA exists, the applicant is NOT eligible for Medi-Cal as a disabled person.

[Refer to “Determining Substantial Gainful Activity (SGA),” page 27-18 for additional information.]

27.28 “Work Activity Report” (MC 273)

This form is given to the applicant to inform him/her of the current SGA limit. It also assists in determining if he/she has any impairment-related work expenses (IRWE) or work subsidies that can be deducted from gross earnings.

[Refer to “Determining Substantial Gainful Activity (SGA),” page 27-18 for additional information.]
27.29“Medi-Cal Report on Adult/Child With Allegation of HIV” (DHCS 7035 A / DHCS 7035 C)

These forms are completed by the medical provider when an adult or child alleges having Human Immunodeficiency Virus (HIV), Acquired Immune Deficiency Syndrome (AIDS), or AIDS-Related Complex (ARC). Upon receipt of this form, the EW must review the case for Presumptive Disability (PD).

[Refer to “HIV/AIDS Policy,” page 33-7 for additional information.]

27.30“Worker Observations - Disability” (DHCS 7045)

This is an optional form for EWs to use to record comments on an individual’s physical, mental, and/or emotional problems.

[Refer to “DDSD — Providing EW Observations,” page 28-1 for additional information.]

27.31“DDSD Transmittal” (SCD 1475)

The “DDSD Transmittal” form (SCD 1475) is a coverletter to the DDSD referral packets. It is used by district office DDSD Liaisons when sending referrals to DDSD.

The SCD 1475 is to be completed online, with two hard copies printed. One copy is to be used as a coverletter, and the other copy is to be kept as a log for tracking purposes. The coverletter must be placed on top of the disability referral packets mailed to DDSD in Oakland. The disability referral packets must be sent to Oakland following the batch process per district office procedures.
27.31.1 Users of SCD 1475

Users of the SCD 1475 are the DDSD Liaisons or the designated professional assistant staff. The designated user must keep a copy of each SCD 1475 sent to Oakland as a log for tracking purposes.

27.31.2 Online Form

The SCD 1475 is a Word template (electronic file-form), and it is only available online in the SSA Intranet website.

27.31.3 Instructions for Completion

The SCD 1475 is an online form with various fields. Some fields are permanent, some fields have drop-down menus, and some fields are blank and need to be completed with free form text. Users of the SCD 1475 must follow these instructions to complete the DDSD Transmittal:

<table>
<thead>
<tr>
<th>FIELD</th>
<th>INSTRUCTIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>TO: DDSD Operations Analyst...</td>
<td>This is a permanent field. No changes are allowed.</td>
</tr>
<tr>
<td>Date Sent To DDSD</td>
<td>This date will automatically be propagated to this field when the user opens the file. No changes are allowed.</td>
</tr>
<tr>
<td>FROM</td>
<td>Users will select one option, by clicking the down arrow, from each of the following six drop-down menus:</td>
</tr>
<tr>
<td></td>
<td>• District Office Fax #</td>
</tr>
<tr>
<td></td>
<td>• Liaison Name</td>
</tr>
<tr>
<td></td>
<td>• Office</td>
</tr>
<tr>
<td></td>
<td>• Location</td>
</tr>
<tr>
<td></td>
<td>• City &amp; Zip Code</td>
</tr>
<tr>
<td></td>
<td>• Phone #</td>
</tr>
<tr>
<td></td>
<td>• Fax #</td>
</tr>
<tr>
<td>DDSD Referral Packets for Disability Evaluation</td>
<td>Users will complete this section by entering the following information regarding the disability referral packets:</td>
</tr>
<tr>
<td></td>
<td>• Case Name (Last, First)</td>
</tr>
<tr>
<td></td>
<td>• Social Security #</td>
</tr>
<tr>
<td></td>
<td>• Case #</td>
</tr>
<tr>
<td></td>
<td>• Comments, if any</td>
</tr>
<tr>
<td></td>
<td>• Total # of Disability Referral Packets sent.</td>
</tr>
</tbody>
</table>

NOTE: Users can enter up to 12 disability referrals on each SCD 1475.
### 27.32 DDSD — EW Procedures

### 27.33 Recording DDSD Pending

When a referral is made to DDSD, the EW must record client’s disability conditions and referral detail in CalWIN on the [Collect Disability/Medical Condition Detail] and [Collect DED Referrals and Results Detail] windows.

DDSD pending cases may be transferred to continuing once all other points of eligibility are cleared and verifications are received.

- EWs must follow-up on each pending DDSD referral every 90 days. [Refer to “Follow-up Action - EW Supervisors and EWs,” page 27-71] and [Refer to “District Office DDSD Liaison,” page 27-71 for more information about required follow-up action.]

**Note:** A Medi-Cal application may never be denied due to lack of response from DDSD.

### DDSD Information Updates (MC 222)

Users will complete this section when sending information update to DDSD by entering the following information:

- Case Name (Last, First)
- Social Security #
- Case #
- Comments, if any
- Total # of MC 222s sent.

REMINDER: The MC 222 must be used when a DDSD packet is pending at DDSD and changes/additional information needs to be submitted to DDSD.

After all the appropriate fields have been selected/completed, the user must print two copies of the DDSD Transmittal form. One copy must be placed as a coverletter on top of the disability referral packets before they are mailed to Oakland, and the other copy must be kept as a log for tracking purposes.

<table>
<thead>
<tr>
<th>FIELD</th>
<th>INSTRUCTIONS</th>
</tr>
</thead>
<tbody>
<tr>
<td>DDSD Information Updates (MC 222)</td>
<td>Users will complete this section when sending information update to DDSD by entering the following information:</td>
</tr>
</tbody>
</table>

- Case Name (Last, First)
- Social Security #
- Case #
- Comments, if any
- Total # of MC 222s sent.

REMINDER: The MC 222 must be used when a DDSD packet is pending at DDSD and changes/additional information needs to be submitted to DDSD.

After all the appropriate fields have been selected/completed, the user must print two copies of the DDSD Transmittal form. One copy must be placed as a coverletter on top of the disability referral packets before they are mailed to Oakland, and the other copy must be kept as a log for tracking purposes.
27.34 Sending the DDSD Packet

Each District Office SSPM must ensure that all DDSD packets are reviewed by an EW Supervisor before they are mailed to DDSD. When the EW Supervisor or DDSD rejects a referral due to incomplete or missing information, a control must be kept to ensure that the packet is corrected and resubmitted within a reasonable time period (ten days).

Important:

Rejected DDSD packets are monitored by the State. The county is subject to corrective action measures if the number of rejected packets is excessive.

27.35 DDSD Address/ Phone

DDSD packets are to be batched and sent at least once weekly to:

Los Angeles State Programs Branch
DDSD-LA State Programs
P.O. Box 992
El Segundo, CA 90245-0992

DDSD Master Files: (310) 615 - 2800
General Fax: (855) 837 - 3238

Fax number to request a copy of the MC 221R after diligent search:
(855) 837 - 3236

Fax numbers for Presumptive Disability (PD) requests:
General Requests: (310) 615 - 2713
Urgent Requests: (855) 837 - 3239
27.36 Delayed DDSD Referrals

27.36.1 Background

Due to the *Radcliffe v. Coye*, et al lawsuit, a “90-Day Status Letter” (MC 179) must be sent when a disability decision will not be reached within 90 days. For new applicants, the 90 days begin from the date of application (the date on SAWS 1). For continuing recipients, the 90 days begin on the date that the client informs the EW that he/she is disabled.

Important:

When completing the MC 221, EWs must remember that the “Date Applied” is not always the date of the most recent SAWS 1. It refers to the date the individual applied as a “disabled person”.

27.36.2 Procedure

In order to comply with this requirement:

• DDSD must send a 90-day status letter to the client when the case is in their possession and a disability decision will not be reached within 90 days.

• The EW must send a “90-Day Status Letter” (MC 179) when the DDSD packet has not been submitted to DDSD by the 80th day. (It may be sent prior to the 80th day if the EW knows the packet will not be forwarded to DDSD by the 80th day.)

• Note the reason for the delay on the letter.

The cause of the delay is not limited to EW caused errors or oversight. It can be that the client delayed in completing the forms, failed to provide necessary information, or even that the client was unable to provide information earlier due to his/her medical condition.

• Attach a copy of the MC 179 to the DDSD referral and note that it has been sent on the MC 221 in the County Worker Comments section.
• If the letter is missing, DDSD will send a letter to the EW requesting that it be sent. The EW must then send the MC 179 to the client and forward a copy to DDSD.

27.36.3 Packets Rejected by DDSD

DDSD returns the entire referral with a cover letter “Notice of Returned Disability Packet”, informing the EW of the error(s) that prevented DDSD from processing the packet. The EW must contact the client in order to make the necessary correction(s). Do NOT mail the DDSD packet and cover letter directly to the client for correction.

• DDSD is not to receive direct inquiries from the client.
• Returning the entire packet to the client could result in a loss of documents and/or unnecessary delays.

If the disability packet needs to be resubmitted, the EW must ensure that all corrective actions have been taken and a copy of the DDSD cover letter “Notice of Returned Disability Packet” is included with the packet. Document the date that the packet is resubmitted to DDSD on the case copy of the MC 221 and in CalWIN [Maintain Case Comments] window. Resubmit through the designated EW Supervisor.

27.36.4 DDSD Actions When Referral is Received

Upon receipt of an application or reevaluation request, DDSD will try to make a determination from available medical evidence.

DDSD will schedule and pay for a consultative examination, if necessary.

• DDSD will contact a source nearest to the applicant’s residence for the appointment.
• DDSD will notify the client of the appointment.

DDSD informs the EW of the disability evaluation results with a “DDSD Disability Determination - Response to MC 221” letter. A determination is to be sent from DDSD to the EW within 90 days (unless client has a pending application for SSI/RSDI).

DDSD may grant Presumptive Disability if available evidence shows a likelihood that disability will be established once complete evidence is obtained and a formal determination is done. These instructions will come from DDSD through the Medi-Cal Program Coordinator.
27.36.5 Reporting Changes to DDSD

In order to prevent delays in the disability determination, EWs must inform DDSD when:

- An applicant withdraws his/her request for Medi-Cal (DDSD will not render a disability decision).

- Medi-Cal is denied or discontinued on the basis of non-medical information; for example, excess property.

- The applicant moves to another county.

- An applicant changes his/her name, address, phone number, or message number.


- The applicant dies, subsequent to the DDSD referral. (Send a copy of the death certificate.)

- The applicant wishes to submit additional medical evidence.

- The applicant's social security number has changed. (DDSD files their records according to the SSN.)

- Other pertinent information which may be of importance to DDSD.

EWs may report new information or changes to DDSD by calling Master Files to identify the assigned analyst and phoning the analyst directly; or, by sending a "DED Pending Information Update" (MC 222) form.

- CalWIN automatically generates a MC 222 when one or more of the following changes are entered into the system and the case is in pending DDSD status. The EW must review the Client Correspondence subsystem to decide whether the MC 222 is appropriate for mailing to DDSD. If not, the MC 222 must be deleted from the print queue.

  - Change of address
  - Change of telephone number
  - Change of social security number
  - Case closed
  - Client deceased
  - Change of county worker
• Change of language/Interpreter

• For all other changes or additional information that must be reported to DDSD, the EW must manually request the MC 222 from the Client Correspondence subsystem or use a shelf-stock form.

Note:
Do not use the County Worker Comments section of the MC 221 to report changes or to update information, as DDSD may reject it as an incomplete packet.

27.37 DDSD Decisions

When a disability determination is made, DDSD notifies the EW of its decision with a “DDSD Disability Determination - Response to MC 221” (SP2 DDSD 221R) or (SP4 DDSD 221R) notification letter. The EW must take certain actions. The required actions are determined by the disability determination made by DDSD. Refer to the sections below to determine the correct action.

DDSD decision letters are numbered and they are returned to the EW with a copy of the MC 221:

<table>
<thead>
<tr>
<th>DDSD Letter</th>
<th>Decision</th>
</tr>
</thead>
</table>
| SP2 DDSD 221R        | • Is Disabled, Is Blind, or Continues to be Disabled;  
|                      | • Is Not Disabled, Is Not Blind, or Ceases to be Disabled (No Rational attached);  
|                      | • No Determination.                                                                               |
| SP4 DDSD 221R/Rationale | • Is Not Disable, Is Not Blind, or Ceases to be Disabled (Rational attached).                  |
| DEP SP1              | • Notice of Returned Disability Packet (Packet returned to EW with reasons).                     |
27.37.1 Is Disabled

When “Is disabled”, “Is blind” or “Continues to be Disabled” of the SP2 DDSD 221R is checked, this indicates that, based on the DDSD medical/vocational evaluation, the applicant is disabled under MN criteria. The onset date provided will take into consideration any request for up to three months retroactive coverage prior to the date of application. The EW must:

1. Approve the application as eligible or reclassify the client as disabled MN, effective with the disability onset date or application date, as appropriate.

2. Record the reexam date in CalWIN if the DDSD decision includes a reexamination date. When sending a reexamination packet include:
   - The old (prior) MC 221, “Disability Determination and Transmittal”, and
   - The new MC 221, and
   - The appropriate number of new MC 220s, “Authorization for Release of Information”, and
   - A new MC 223 (for over age 18) or MC 223C (for under age 18)

Note: The beneficiary is still considered to be disabled until DDSD notifies you otherwise. If the beneficiary fails, without good cause, to cooperate in completing the necessary reexamination DDSD forms, he/she must be discontinued.

27.37.2 Is Not Disabled

When “Is not disabled”, “Is not blind”, or “Ceases to be Disabled” of the SP2 DDSD 221R or SP4 DDSD 221R is checked, it indicates that based on the DDSD medical/vocational evaluation, the applicant does not meet MN disability criteria. The EW must:

1. Deny/discontinue the applicant when disability is the only basis of eligibility.

2. Include a copy of the rationale “Explanation of Disability Determination” provided by DDSD with the denial/discontinuance NOA. Do NOT send the applicant a copy of the actual decision. The rationale for the DDSD denial is an unnumbered and unsigned sheet which explains the reason for the denial and a copy must be sent to the client.
3. Determine eligibility under any other program prior to discontinuance/denial.

27.37.3 No Determination

“No Determination” or “Z Basis Codes” on the “DDSD Disability Determination - Response to MC 221” letter (SP2 DDSD 221R) means that DDSD is unable to make a determination. This usually means that DDSD does not have sufficient information and the client has failed to contact or cooperate with DDSD as requested. Thus, DDSD needs further help from the EW in order to obtain the information required to make the disability determination.

Below are examples of why disability cannot be established:

- Applicant failed to respond to phone calls and letters;
- Applicant failed to attend requested consultative examination;
- Applicant requested to discontinue the evaluation process;
- Applicant was discontinued from SSA disability for non-disability reasons, however the SSA reexam date is past due;
- Applicant if working and possibly earning in excess of the SGA amount, form MC 272 is needed, etc.

Do NOT deny the DDSD applicant for lack of disability when the DDSD letter states “No Determination”. If the client failed to cooperate with DDSD, attempt to obtain the requested information and a good cause determination must be made (determine if the applicant had good cause for not cooperating with DDSD). If additional information is needed from the EW (such as a missing form), follow instructions on the DDSD letter immediately and resubmit packet without delay.

When the DDSD letter states “No Determination”, the EW shall:

<table>
<thead>
<tr>
<th>Step</th>
<th>Action</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Provide the new address, if known, or other needed information to DDSD and resubmit the packet.</td>
</tr>
<tr>
<td>2.</td>
<td>Attempt two separate contacts, if information is not known, to obtain client’s cooperation and/or the needed information, and resubmit the packet to DDSD.</td>
</tr>
</tbody>
</table>
3. **Determine “good cause” if the reason for a “no determination” was “failure to cooperate”**.

   Good cause may consist of, but is not limited to:
   
   • EW failure to provide the appropriate forms to the client.
   • EW failure to inform the client that failure to cooperate with DDSD will result in denial/discontinuance.
   • The applicant moved and did not receive the request for information.
   • The applicant was unable to get the information to DDSD in the time allowed because of physical/mental illness or incapacity
   • Level of literacy or social/language barriers preclude the client from comprehending the instructions.
   • The client did not have adequate transportation to reach a required destination.

<table>
<thead>
<tr>
<th>If...</th>
<th>Then...</th>
</tr>
</thead>
<tbody>
<tr>
<td>It is LESS than 30 days since DDSD returned the packet, and The client has good cause, and No new medical conditions or treatment services are claimed,</td>
<td>Complete a new MC 221 carefully documenting that good cause was found, and Check “Resubmitted Packet” in Item 8, “Type of Referral”, and Resubmit a LIMITED packet containing the new MC 221 to DDSD.</td>
</tr>
<tr>
<td>It is MORE than 30 days since DDSD returned the packet, and The client has good cause,</td>
<td>Complete a new MC 221 indicate that good cause was found, and Check “Resubmitted Packet” in Item 8, “Type of Referral”, and Resubmit a FULL packet containing the new MC 221 to DDSD.</td>
</tr>
<tr>
<td>The client claims new medical conditions, and/or new or additional medical sources or information, and The client has good cause,</td>
<td>Complete new MC 221 and MC 223 (for over age 18) or MC 223C (for under age 18), and Have client complete additional MC 220s as necessary, and Resubmit a FULL packet containing the new MC 221, MC 223 (for over age 18) or MC 223C (for under age 18), and MC 220s to DDSD.</td>
</tr>
<tr>
<td>Good cause does not exist,</td>
<td>Deny application or discontinue client for failure to cooperate or loss of contact if no other linkage exists.</td>
</tr>
</tbody>
</table>
27.37.4 “No Determination” (Noncooperation by Doctor)

When an evaluation cannot be completed because the doctor does not cooperate in producing records:

- DDSD will return the packet to the EW indicating that the doctor did not cooperate.
- The EW must deny the pending DDSD Medi-Cal case.
- The EW shall instruct the applicant to file an appeal, clearly declaring the reason for the appeal when filing.

27.38 DDSD Status Reports

27.38.1 Description

DDSD produces two separate quarterly case status reports:

- “PENDING MEDI-CAL DISABILITY CASES” — shows all the cases that are still pending with DDSD, and
- “CLOSED MEDI-CAL DISABILITY CASES” — shows all the cases that DDSD has closed during the quarter.

Important:

This list is NOT a substitute for the DDSD determination letter. If DDSD has closed a case and the EW has not received the decision, a duplicate must be requested by contacting DDSD.

Cases may appear on the report(s) more than once. For example, a case with the Basis Code “Z55” means that the DDSD referral was received and rejected back to the EW due to an error in the DDSD packet. When the case is subsequently corrected and re-referred, the name will appear on the pending list. Once DDSD has made a decision, the name will again appear on the list of closed cases with a different basis code.

Occasionally our DDSD referrals will be sent to the Los Angeles bureau for processing in order to equalize DDSD's workload.
The lists contain the following information:

**Pending List**

- Applicant's Last Name
- Applicant's First Name
- SSN (This is how DDSD files their cases.)
- LVL - Indicates the Type of Referral (Initial, Reevaluation, Reexamination, etc.)
- Birth Date
- Applied Date (the date of application entered by the EW on the MC 221)
- Receipt Date (The date case was received by DDSD.)
- CWD (Our county number, 43.)
- Code (Used by DDSD only, local CWD office number.)
- Branch (Indicates the DDSD office processing the disability determination.)
- DEA Last Name (Last name of the DDSD analyst assigned to the case.)

**Closed List**

- Applicant's Last Name
- Applicant's First Name
- SSN (This is how DDSD files their cases.)
- LVL - Indicates the Type of Referral (Initial, Reevaluation, Reexamination, etc.)
- Birth Date
- Applied Date (the date of application entered by the EW on the MC 221)
- Receipt Date (The date case was received by DDSD.)
- DEC. (Decision Code: A = Allowed, D = Denied, N = No Determination.)
- BASIS CODE (Reason case was closed. [Refer to “Basis Codes,” page 27-68.])
- Closure Date (The date DDSD closed their case.)
- CWD (Our county number, 43.)
- Code (Used by DDSD only, local CWD office number.)
- Branch (Indicates the DDSD office processing the disability determination.)
- DEA Last Name (Last name of the DDSD analyst assigned to the case.)

### 27.38.2 Basis Codes

The following is a list of DDSD decision Basis Codes.

**Note:**

If Basis Code is not listed below, contact the Medi-Cal Program Coordinator.
Allowance Basis Codes (Disability Approved)

A55  Reexamination Case Review - Continuance of Disability
A61  Impairment meets level of severity in Listing of Impairments
A62  Impairment(s) equals level of severity in Listing of Impairments
A63  Medical/vocational considerations result in favorable decisions
A64  Medical/vocational considerations - arduous unskilled work
A65  Disabled child claim - medically equals severity of Listing
A66  Disabled child claim - functionally equals severity of Listing
A98  Hearing Reversal Decisions
A99  Adoption of federal (SSA) allowance/continuance decision
B61  Allowance for statutory blindness

Denial Basis Codes (Disability Denied)

N30/N41*  Impairment not severe
N31/N42*  Capacity for SGA — any past relevant work
N32/N43*  Capacity for SGA — other than past relevant work
N34/N45*  Impairments prevent SGA for less than 12 months
N35/N46*  Impairments prevent SGA at time of adjudication/not expected to prevent SGA for a period of 12 months
N36  Claimant refuses to seek treatment at a county facility
N39  Drug/Alcohol Addiction Material to Decision
N41  Evaluation for blindness only - statutory blindness criteria not met
N43/N51*  Disabled child claim-impairment severe, but does not meet or medically/ functionally equal
N44  Child claim-impairment not severe. With/without visual impairment alleged
N55  Reexamination case review - Cessation of disability
N57  250% WDP Denial - based on evidence in file, the applicant does not meet the Social Security Administration’s definition of disability
Z53  Adoption of federal (SSA) denial/cessation decision
Z59  Adoption of federal (SSA) denial/cessation decision where DA&A was material to the decision

*Indicates visual impairment alleged.
No Determination Basis Codes

“Z” codes indicate that a disability determination has not been made. Generally, EW action is required. After taking appropriate action, the EW must resend the DDSD packet to DDSD. A 90-Day Status Letter (MC 179) must be sent to the client (except for Z53 and Z59 cases), if it is now the 80th day, or it is evident that DDSD will not be able to make a decision by the 90th day. If an MC 179 is sent to the client, include a copy in the DDSD packet.

[Refer to “DDSD Decisions,” page 27-63 if no determination is made.]

“Z” Codes

<table>
<thead>
<tr>
<th>Code</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>Z55</td>
<td>Case returned to county for packet deficiency</td>
</tr>
<tr>
<td>Z56</td>
<td>No determination closures (includes withdrawal and failure issues)</td>
</tr>
<tr>
<td>Z70</td>
<td>Duplicate cases - prior case in same DDSD office</td>
</tr>
<tr>
<td>Z71</td>
<td>Duplicate cases - prior case in other DDSD office</td>
</tr>
</tbody>
</table>

27.38.3 Monitoring Requirements

DDSD status reports are received quarterly from DDSD. One copy for each District Office is distributed by the Medi-Cal Program Coordinator to the DDSD Liaison.

27.38.4 SSPMs

Each SSPM will decide how the reports will be maintained at their District Office, for example, if one copy will be placed in a designated area, or if additional copies will be made for each EW Supervisor.

All reports are to be kept on file. Do not discard earlier listings when new ones are received.
27.38.5 Follow-up Action - EW Supervisors and EWs

EW Supervisors and EWs are to use the listings to ensure that:

- DDSD has received the referral,
- Rejected packets (Code Z55 cases) are corrected and returned to DDSD,
- DDSD cases pending 90 or more days are checked to see if DDSD has made a decision, and
- To request a duplicate DDSD decision if none was received.

27.38.6 DDSD Decision Needed

If a duplicate DDSD decision is needed, EW must send the request to the Medi-Cal Program Coordinator with client’s name, SSN, DOB and the date of application. The Coordinator will forward the request to DDSD.

Important:

Duplicate DDSD decisions should be requested as soon as possible after DDSD has closed the case. The original case documents are only kept at the DDSD office for a few months, after which they are sent to state archives.

27.39 DDSD Inquiries

27.39.1 District Office DDSD Liaison

District Office DDSD Liaison may contact DDSD Master Files directly to inquire about the status of a disability referral. The DDSD Liaison must review the quarterly DDSD computer listings prior to calling the DDSD office [Refer to “DDSD Status Reports,” page 27-67.]

Reminder:

EWs should not contact the DDSD office directly. If there is a question regarding a referral, the EW must consult with the DDSD Liaison.
27.39.2 Medi-Cal Program Coordinator

Other contacts with DDSD are to go through the Medi-Cal Program Coordinator to our assigned county liaison in Oakland, such as:

- All requests for duplicate DDSD decisions.
- Requests to expedite a DDSD referral.
- Other problems, that may be causing difficulties in district offices.

When in doubt, please confer with your District Office DDSD Liaison.

27.40 DDSD Referral Packets

There are two types of DDSD Referral Packets: FULL and LIMITED.

27.40.1 Full Packet

A Full DDSD Packet Includes:

- A copy of prior MC 221, if applicable, and SP2 DDSD 221R, and
- A new MC 221 with Item #8 properly marked (i.e., reexamination, redetermination, initial referral, etc.), and
- MC 223 (for over age 18) or MC 223C (for under age 18), and
- MC 220 for every medical source listed on the MC 223 or MC 223C.

27.40.2 Limited Packet

A Limited DDSD Packet includes:

- A copy of the prior MC 221 if available, and SP2 DDSD 221R, and
- A New MC 221 with the reason for the limited referral clearly stated in the "County Worker Comments" section.

NOTE: Indicate on Item #10 if the referral is for redetermination after break in aid of 12 months of less, unless a FULL referral packet is sent.

Reminder:
The DDSD referral packet must be scanned into the IDM system.
27.40.3 Options to Process Disability Evaluation Referral Packets

At the client’s request, MC 223 (for over age 18) or MC 223C (for under age 18), and the MC 220 can be completed using one of the following three options:

- The MC 223 or MC 223C and the MC 220s can be mailed to the client to be completed, signed and returned to the EW.
- The client may request a face-to-face interview to complete the MC 223 or MC 223C and the MC 220s.
- The EW can complete the MC 223 or MC 223C through a telephone interview with the client. Then the MC 223 or MC 223C and MC 220s can be mailed to the client to be signed, dated and returned to the EW.

27.41 DDSD — Special Referrals

27.42 Limited DDSD Referral

There are a few circumstances when a full DDSD packet is not required, as explained below.

27.42.1 Allowable Circumstances

A limited DDSD packet may only be sent under the following circumstances:

Important:

Limited DDSD referrals which do not meet the specific criteria listed below are likely to be rejected by DDSD for a full packet.

1. When the referral is sent within 30 days of DDSD’s decision for a reevaluation and no new treatment sources are alleged. [Refer to “DDSD — Reexaminations, Redeterminations, and Reevaluations,” page 32-1 for more information.]
2. When an earlier onset date on an approved case is needed, it is being requested within 12 months of application, and no new treating sources are alleged for the earlier onset date.

Note:
If DDSD is unable to establish an earlier onset date with the information available, the packet may be returned with code Z56 to request additional information.

3. When the client is discontinued from SSI/SSP due to income or resources and he/she is not receiving Social Security Disability benefits. This includes clients who were entitled to IHSS prior to being discontinued from SSI due to earnings.

Important:

The EW must first make a diligent search with SSA, MEDS (INQX) and/or IEVS to verify the reason client was discontinued from SSI, which could eliminate the need for a limited packet being sent to DDSD for verification. If a referral must still be sent, annotate on the MC 221 County Worker Comments section why the SSI case status was unobtainable. Packets without this information will be returned by DDSD. [Refer to “Referral for Former SSI/SSP Recipient - Discontinued for Reasons Other than “Cessation of Disability”,” page 27-76 for more detail.]

4. When an application is made on behalf of a deceased client and the appropriate documentation of death is sent. However, if death occurs in one month, and a disability determination is needed for prior months; or if the cause of death is not related to the disabling condition, a full DDSD packet is needed.

Note:
If the death certificate is not available, have the next-of-kin sign the MC 220s.

5. When after a diligent search attempt with SSA, MEDS (INQX) and/or IEVS to obtain SSI case status and the EW is still unable to verify receipt of SSI benefits, the EW may request only verification of SSI benefits for IHSS purposes from DDSD.

27.42.2 Required Forms

A “limited” DDSD referral packet only requires the following forms:

• A new “Disability Determination and Transmittal” (MC 221) with the reason for the limited referral clearly stated in the “County Worker Comments” section, and...
27.43 DDSD Referral for a Retro Month

Follow these instructions when DDSD must determine disability for a retroactive month:

27.43.1 New Applicant

When the client is applying for retroactive Medi-Cal and there has been no prior DDSD referral, a full DDSD packet must be sent.

27.43.2 DDSD Pending

When a DDSD decision is still pending and the client subsequently requests Medi-Cal for a retroactive month (an earlier onset date is needed), send an MC 222 to DDSD and specify the retro months requested under the “Other” section.

27.43.3 After DDSD Approval

When the need for retroactive Medi-Cal is identified within 12 months of the original application, the EW will complete a limited referral:

- Check the “Retro-onset” box in Item 8 of the new MC 221, and
- Attach a copy of the prior DDSD decision which shows the disability allowance.

Send a full DDSD packet if the request for retro onset is being sent more than one year after the original application.

Important:

The above statement only applies when a court order, appeals decision or a state program decision require that a DDSD referral be made. Otherwise, an application for retroactive coverage must be submitted within one year of the month for which retroactive coverage is needed.
27.44 Referral for Former SSI/SSP Recipient - Discontinued for Reasons Other than “Cessation of Disability”

27.44.1 Purpose

Clients under age 65 who are discontinued from SSI/SSP for reasons other than “cessation of disability” (e.g., excess income or resources) and who are NOT receiving Social Security Disability benefits (Title II) must be referred to DDSD to determine if the disability established by SSA still exists. (This can also include persons who are in LTC).

Reminder:
Before making a referral to DDSD, the EW must first make a diligent attempt with SSA, MEDS and/or IEVS to verify the reason why SSI was discontinued. If a referral must still be made, annotate on the County Worker Comments section of the MC 221 why the SSI case status was unobtainable. Packets without this information will be returned as code Z56 by DDSD.

These individuals fall under the Craig v. Bonta court settlement, which entitles them to an extension of Medi-Cal after the SSI discontinuance, pending a determination of ongoing Medi-Cal eligibility. [Refer to “Procedures became effective January 1, 1982 and became obsolete effective June 30, 2002. The Craig v. Bontá lawsuit superseded the Ramos v. Myers court order,” page 67-19 for additional information.]

27.44.2 DDSD Referral

Send a limited packet to DDSD after diligent attempt to obtain SSI case status is unsuccessful. [Refer to “DDSD Referral Packets,” page 30-15 for more information.]

• Annotate on the MC 221 County Worker Comments section:
  • SSI/SSP discontinued for reasons other than cessation of disability, and
  • The steps taken to obtain SSI case status and the reason why the information was unobtainable.
• Client continues to receive Medi-Cal under the pending SB-87 redetermination Aid Codes (1E, 2E, and 6E). Do not approve Medi-Cal until DDSD decision is received.

27.44.3 DDSD Approval

DDSD may be able to adopt SSA's disability approval and onset date by querying SSA records. If so, the MC 221 will be returned to the EW with disability approval indicated.

27.44.4 No Decision

If SSA's reexam date has passed or if SSA's disability decision cannot be verified, DDSD will return the MC 221 to the EW with decision code Z56. A full DDSD packet must be sent.

27.45 Referral for Former SSI/SSP Recipient - “Cessation of Disability”

27.45.1 Purpose

Clients under the age 65 who are discontinued from SSI/SSP due to “cessation of disability” are entitled to receive zero share of cost extended Medi-Cal throughout the:

• Social Security Administration (SSA) appeal process, including the 65 day period in which an appeal may be filed (Aid Code 6N), and

• County Medi-Cal redetermination process (Aid Code 6E).

When the SSA decision becomes “final,” the individual's Aid Code will be changed from 6N to 6E and his/her name added to the “Exception Eligibles Report.” The EW must determine ongoing Medi-Cal under another linkage factor (e.g., AFDC-MN) by completing the SB 87 Redetermination Process. [See “Procedures became effective January 1, 1982 and became obsolete effective June 30, 2002. The Craig v. Bontá lawsuit superseded the Ramos v. Myers court order,” page 67-19 for more detail.]
27.45.2 DDSD Referral

Due to the 1990 federal disability regulations, the Social Security disability decision is binding. DDSD is not allowed to make an independent disability decision if the applicant claims the same disabling condition previously considered by Social Security within the past 12 months. [Refer to “Disability Determination Service Division (DDSD) Referral Limited by SSA Decision,” page 27-9.]

Therefore, a DDSD referral is required only when the individual alleges a new disabling condition not already considered by Social Security. [Refer to “Disability Determination Service Division (DDSD) Decision Chart,” page 27-15 for additional information.] The EW must:

• Send a full packet to DDSD.
• Write “Former SSI Payment Status N07 Recipient, Alleges New Impairment” in the Worker Comments Section of the MC 221.
• Record client’s disability conditions and referral detail in CalWIN on the [Collect Disability/Medical Condition Detail] and [Collect DED Referrals and Results Detail] windows. See CalWIN Announcement #120.1 for instructions.

27.45.3 No Decision

DDSD will query MEDS for SSA appeal information upon receipt of a DDSD referral. DDSD will return to the EW all referrals with an SSA disability appeal pending. The MC 221 will be marked “Z56” (no decision made). The EW must deny the case due to the receipt of extended Medi-Cal.

Note:

The final SSI decision, and, if applicable, the hearing status, is posted on the Medi-Cal Eligibility Data System (MEDS).
27.46 DDSD — Reexaminations, Redeterminations, and Reevaluations

27.47 RSDI and Disability

27.47.1 Overview

The receipt of Social Security RSDI disability payments establishes disability status for Medi-Cal. All reexaminations required to determine a continued disabled status are requested by Social Security. The Social Security decision on disability status is binding. Medi-Cal eligibility must be continued as long as Social Security benefits based on the client's disability are being paid and the individual is otherwise eligible.

27.47.2 Verification Requirement

Intake

RSDI disability status and reexamination date must be verified at each application.

The EW must use the IEVS report to gather necessary information. If additional information or clarification is needed, the EW must submit a communication form “Referral To/From Social Security” (SCD 169) or the “Social Security Information Request or Referral” (SCD 1955) to Social Security requesting, in the “Other Information Requested” or “Comments” area, the:

- Disability onset date (establishing the beginning date of disability linkage), and
- Medical reexamination date (enter in CalWIN when reexam date becomes available).
Redetermination

Receipt of a Social Security RSDI disability payment(s) must be verified at each annual Medi-Cal redetermination. The disability onset date and/or medical reexamination date must be verified with Social Security if the dates are unknown. An IEVS report or an SCD 169 or any other verification from Social Security can be used.

27.47.3 Follow-Up

As long as the client continues to receive RSDI benefits (Title II) no follow-up on the reexam date is required. SSA's determination is binding until SSA revises its decision. If Title II benefits are stopped, a DDSD packet must be initiated to determine if the client is still disabled.

27.48 Determined Disability

27.48.1 Overview

When the disability status of a Medi-Cal client is established by DDSD, the EW must periodically submit the appropriate DDSD referrals in order to determine if the client continues to be disabled.

27.48.2 Types of Referrals to DDSD

The are three instances when periodic DDSD referrals may be necessary:

- Reexamination
- Redetermination
- Reevaluation.

The type of referral must be clearly identified on the “Disability Determination and Transmittal” (MC 221). Include a copy of the prior MC 221 as well as the attached SP2 DDSD 221R or SP4 DDSD 221R whenever possible to provide a more complete picture of the client’s overall medical condition.
27.49 Reexaminations

Most reexaminations occur when a mandatory reexam date set for expected medical improvement is due. The reexam date is shown on the prior DDSD decision (SP2 DDSD 221R). In most cases, the client will continue to be considered disabled until his/her medical condition has improved and has been determined no longer disabled. Medical reexams are needed whether a federal decision is involved or not.

DDSD determines a Medical Reexamination Diary (MRD) date when the disability status is approved for a Medi-Cal beneficiary. The MRD date is the “Reexam Date” indicated on the DDSD decision. The due dates range from six months to about seven years depending on the individual’s likelihood of medical improvement.

Do NOT send a disability referral if the reexam date is not yet due even if there is a break in aid, UNLESS the client’s medical condition has improved significantly.

If the client’s case shows that Social Security Administration (SSA) determined the client to be disabled and DDSD adopted SSA’s decision, the EW must contact SSA to determine whether the disability continues. If SSA benefits continue, no referral to DDSD is needed when the reexam date is due, as SSA’s determinations are binding until SSA revises its decision. However, SSA will not perform a reexam if client is no longer in pay status and SSA’s record show that the individual was discontinued for non-disability reasons.

If DDSD adopted an SSA approval and SSA finds that the client is no longer disabled, procedures listed under “Federal Disability Decision Involved” must be followed.

Medi-Cal benefits can not be discontinued until the SSA decision has become final, meaning that the client no longer has an appeal pending at SSA on the cessation issue. In this instance, EWs will need to check (e.g., at each annual redetermination) with the client or with SSA to obtain status of the SSA appeal.

27.49.1 No Federal Decision Involved

A medical reexam is needed when one of the following occurs:

- DDSD through DHCS notifies the Medi-Cal Program Coordinator of cases currently due or past due for medical reexam. Referrals should be submitted to DDSD within 90 days from the notification date.
• The EW observes or receives information that the client’s medical condition may have improved.

• During a case review, the EW notices that the medical reexam date is past due.

The EW will submit a full disability packet to DDSD for each reexam case. A full packet consists of a current MC 221 and a copy of the prior MC 221, an MC 223 (for over age 18) or MC 223C (for under age 18) with a signed and dated MC 220 for each medical source listed on the MC 223 or MC 223C. Any new medical records or reports must also be included.

27.49.2 Federal Decision Involved

A medical reexam is needed when one of the following occurs:

• When DDSD initially granted disability status and a reexam is due, if subsequent SSA Title II disability claim is allowed, DDSD will adopt the federal medical reexam date if it is not pending or if it is set at a future date.

• If DDSD receives a referral from the EW on a case where an SSA Title II medical reexam is NO LONGER pending, DDSD will return the MC 221 with the following comment: “Medi-Cal for this individual is based on current federal Title II disability benefits; the federal case takes precedence and SSA’s determination is binding until SSA revises its decision.”

• If DDSD receives a referral from the EW on a case where the federal Title II medical reexam IS pending, DDSD will return the MC 221 with the following comment: “Medi-Cal for this individual is based on current federal Title II disability benefits; the federal case takes precedence and SSA is currently conducting a reexam. The EW should follow up on disability status with SSA in 60-90 days.”

• When DDSD initially granted disability status, however, a subsequent federal disability denial determination was made. The client has filed an SSA appeal on the federal denial. The SSA appeal is pending or it is less than 90 days since the most recent SSA denial. DDSD will not complete a reexam on these cases. Instead, DDSD will close the case as a “No Determination” and reset the medical reexam date to a future date. DDSD will return the MC 221 with the annotation: “An appeal is pending on a federal Title II/SSI denial/cessation; the case remains under SSA jurisdiction. A revised reexam date has been set for (date). At that time, DDSD will determine whether a medical reexam is necessary.”
Under federal and state regulations the following applies: “If an individual receiving Medi-Cal based upon disability is later determined by SSA not to be disabled, and the client is not eligible for Medi-Cal on some other basis, this client is entitled to receive continued Medi-Cal eligibility if he/she timely appeals the SSA disability determination.”

Therefore, EWs will continue to aid a Medi-Cal client who was approved Medi-Cal eligibility due to disability and who subsequently receives a disability denial determination from SSA, if the client timely appeals the SSA denial. Once the SSA disability appeal is no longer pending, and the SSA’s final decision is a denial, DDSD will complete their medical reexam at that point.

**Exception**

A referral to DDSD for a reexamination is NOT required when all of the following conditions exist:

- DDSD initially grants disability status, and
- Subsequently, a federal disability denial determination was made within 12 or more months prior to DDSD’s reexam date, and
- The client has exhausted all federal appeal rights.

**Example:**

Per case information, DDSD determined Jane Doe disabled as of September 2002 with a reexamination date of January 2010. She applied for SSI on January 2003 and Social Security Administration (SSA) granted her SSI-PD (presumptive disability). SSI-PD is usually given to individuals who meet the SSI-PD criteria during the time SSA is making a formal disability determination. In July 2003, SSA made an unfavorable decision. SSA’s disability decision is binding and overrides DDSD’s initial decision making DDSD’s reexamination date invalid. If she has exhausted all federal appeal rights (the EW can check the INQP screen on MEDS or contact SSA to find out), she is no longer considered disabled and must be denied/discontinued unless there are other linkage/deprivation or she claims a new condition of disability.

**27.49.3 HIV Exception**

Federal regulations released in 2002 exempt Human Immunodeficiency Virus (HIV) cases from Social Security’s Continuing Disability Review process. Based on this federal regulation, SP-DDSD also exempts HIV cases from their reexamination process.
If DDSD allows an initial case that has HIV involvement, they will annotate on the decision “DDSD Disability Determination” (SP2 DDSD 221R) that the case will be exempt from the reexamination process until further notice. DDSD will set a seven year reexam date; however, EWs must not require a client with HIV to complete the reexamination when it becomes due.

27.50 Redeterminations

This type of referral is made for a client who was previously determined federally disabled AND DDSD previously adopted the federal decision and meets ALL of the following conditions:

- Is discontinued from Medi-Cal for a reason other than disability, AND
- Reapplies for Medi-Cal alleging that disability continues to exist, AND
- Is not currently in receipt of SSA/SSI disability benefits (Title II or Title XVI).

A LIMITED DDSD referral packet is sent if the reexam date is not yet due or past due. Otherwise, a FULL DDSD referral packet must be submitted in the following circumstances:

- Client has been discontinued for more than 12 months,
- There is no reexam date or it is unknown (Exception: Craig v. Bonta individuals whose SSI were terminated due to a reason other than disability, a limited packet may be sent to find out the reexam date if the information is unobtainable from SSA, MEDS, and/or IEVS.)
- Reexam date is due or past due,
- Client’s condition noticeably improved,
- SSA’s claim is pending, or
- SSA’s denial determination was made more than 12 months in the past.

Note:
A copy of the prior MC 221 must be included with either a “limited” or a “full” DDSD referral packet. Unless there is linkage other than disability and the reexam date is due or past due, the case must be placed in pending status and not granted Medi-Cal benefits until DDSD returns the case with a determination.
There are two types of referral packets: LIMITED and FULL.

<table>
<thead>
<tr>
<th>Limited Packet Includes:</th>
<th>Full Packet Includes:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Copy of prior MC 221 (note on new MC 221 if not available), SP2 and</td>
<td>• Copy of prior MC 221, SP2 (note on new MC 221 if not available), and</td>
</tr>
<tr>
<td>• A new MC 221 marked:</td>
<td>• New MC 221 marked</td>
</tr>
<tr>
<td>a. “Redetermination” in Item 8, and</td>
<td>“Redetermination” in Item 8, and</td>
</tr>
<tr>
<td>b. “Redetermination after break in aid of 12 months or less” in Item 10 is required on ALL redeterminations unless full referral packet is required.</td>
<td>• MC 223 (for over age 18) or MC 223C (for under age 18) and</td>
</tr>
<tr>
<td></td>
<td>• MC 220 for every medical source.</td>
</tr>
</tbody>
</table>

Upon receipt of a disability packet, DDSD will check with SSA to determine if there has been a subsequent federal SSA Title II or SSI disability determination within the past 12 months. If there has been a subsequent federal disability denial/cessation determination that is binding on the State, DDSD will adopt the denial/cessation and instruct the EW to refer the client back to SSA.

If the EW receives a no determination decision from DDSD due to the above, the EW must deny the case if there is no other linkage for Medi-Cal.

Example:
DDSD adopted a federal disability determination in January 1997 with a June 2000 reexam date. Client’s Medi-Cal was discontinued in April 1999 for reasons other than disability and reapplied for Medi-Cal in November 1999. The client is not currently in receipt of disability benefits. The EW must pend the application if there is no other linkage and submit a limited disability packet.

27.51 Reevaluations

This type of referral is made within 90 days of the decision from DDSD when the EW believes that the DDSD is incorrect. In general, a “full” DDSD referral packet is needed.
**Exception:**
When a DDSD referral packet is sent within 30 days of DDSD’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 may be sent. DDSD will attempt to make a decision with the available information. However, if additional information is needed, DDSD may return the referral packet.

### 27.51.1 DDSD Independent Review Claim

Send a DDSD referral packet when a client, or someone acting on the client’s 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 10/7/00, DDSD denied a client who alleged disability due to heart disease. On 11/27/00, the client’s husband called to inform the EW that his wife had a serious heart attack and was admitted to the hospital. Submit a full DDSD referral packet, as it is over 30 days since the prior decision.

### 27.51.2 DDSD Adopted SSA’s Decision

**New Condition**

If DDSD 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 DDSD.

**Example:**
An SSI claim was denied because client’s leg problem was not disabling. Client then learned that he/she has cancer, which was not considered in SSA’s decision, and client decided not to appeal the SSI denial. Refer claim to DDSD.

**Same Condition**

If DDSD 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 the 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 disability referral packet to DDSD.

27.52 DDSD Referral Chart

While “reexaminations” are the most common reason for resubmitting a DDSD referral, other types of referrals are sometimes necessary.

EWs must use the chart below to identify the type of referral, the criteria, the forms to include in the DDSD packet, and to determine the client's eligibility status while a DDSD decision is pending.

Important

Include a copy of the previous MC 221 whenever possible, as failure to do so may result in an inadequate assessment of the person's overall medical condition or insufficient medical evidence.

27.52.1 Reexamination Referral Procedures

All medical reexaminations for Medically Needy Only (MNO) beneficiaries must be performed timely. The Department of Health Care Services (DHCS) will assume the responsibility for tracking all reexamination disability referrals until the process has been completed. DHCS will send a listing of clients to corresponding counties requesting a FULL disability packet be sent to DDSD for these clients.

Responsibility Chart

The following chart indicates who is responsible and describes the corresponding referral process.

<table>
<thead>
<tr>
<th>RESPONSIBILITY</th>
<th>PROCESS DESCRIPTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>DDSD</td>
<td>DDSD will:</td>
</tr>
<tr>
<td></td>
<td>• Continue to generate monthly listings of MNO disability cases that are due or past due for a medical reexamination.</td>
</tr>
<tr>
<td></td>
<td>• Forward the listings to DHCS to purge them and then distribute to affected counties. If the disability packet has not been received in DDSD within 90 days of the original listing date, DDSD will generate a 90-day past due listing and forward it to DHCS for appropriate action.</td>
</tr>
<tr>
<td>RESPONSIBILITY</td>
<td>PROCESS DESCRIPTION</td>
</tr>
<tr>
<td>----------------</td>
<td>---------------------</td>
</tr>
</tbody>
</table>
| DHCS           | After receipt of the original case listing, DHCS will:  
|                | • Purge the listing and forward it to the corresponding Medi-Cal Program Coordinator in each county for processing.  
|                | • Forward a copy of the purge listing to DDSD Operations Analysts in both branches.  
|                | • Send a letter (after DHCS receives the 90-day past due listing from DDSD) and enclose the past due listing to the corresponding Medi-Cal Program Coordinator, informing them that the disability packet has not been received by DDSD.  
|                | • Request counties through the letter to forward a FULL disability packet to DDSD within 45 days from the date of the letter or advise DHCS why a disability packet was not sent. The reason(s) for the delay should be annotated on the past due listing by the corresponding Medi-Cal Program Coordinator and forwarded back to DHCS.  
|                | • Follow up with counties as appropriate. |
| Medi-Cal Program Coordinator | Upon receipt of the initial reexamination listing from DHCS, the Medi-Cal Program Coordinator will forward the listing to DDSD Liaisons of the affected offices for distribution to EW Supervisors. |
| EW Supervisor | Instructs the assigned EW to submit a FULL disability packet to DDSD. |
| Eligibility Worker (EW) | The EW must:  
|                | • Submit a FULL disability packet on each identified case to DDSD within 45 days, and  
|                | • Check the “Reexamination” box in Item 8 of the “Disability Determination and Transmittal” (MC 221), or  
|                | • Notify the EW Supervisor by documenting on the listing:  
|                | • Why the disability packet was not sent (e.g., case discontinued because client refused to cooperate), or  
|                | • The date the disability packet was sent to DDSD and the action taken.  
|                | • NOTE: EWs must not discontinue any case if a reexamination is due/past due. A FULL disability packet must be submitted. |
| EW Supervisor | The EW Supervisor must:  
|                | • Review the FULL disability packet for completeness and forward it to the DDSD Liaison, or  
|                | • Follow up and notify the DDSD Liaison of any other action taken by the assigned EW. |
The reexaminations procedures are as follows:

<table>
<thead>
<tr>
<th>Referral Sent When...</th>
<th>What to Include:</th>
<th>Eligibility Status Pending Reexamination</th>
</tr>
</thead>
<tbody>
<tr>
<td>An evaluation of disability is needed to see if medical improvement has occurred when: • DDSD has established a reexam date, or • Client becomes employed, or • Other circumstances lead EW to believe condition has improved, or • The monthly Reexamination List indicates a reexam is required.</td>
<td>• A copy of prior MC 221 (note on new MC 221 if not available), SP 2, and • A new MC 221 marked “Reexamination” in item 8 and state reason for reexam in item 10, • A new MC 223 or MC 223C (not a photocopy of old MC 223/MC 223C), • MC 220 for every medical source, and • Any new medical records, if available.</td>
<td>Eligibility continues UNLESS: • The client fails to cooperate with DDSD, or • Whereabouts unknown, loss of contact, or • DDSD decides client is no longer disabled and there is no other linkage, or • Another reason for discontinuance exists, e.g., excess property.</td>
</tr>
</tbody>
</table>

### 27.52.2 Redetermination Referral Procedures

The Redetermination procedures are as follows:

<table>
<thead>
<tr>
<th>Referral Sent When...</th>
<th>What to Include:</th>
<th>Eligibility Status Pending Redetermination</th>
</tr>
</thead>
<tbody>
<tr>
<td>Client meets all of the following criteria: • Previously determined federally disabled and DDSD adopted the federal decision, and • Was discontinued for a reason other than disability (break in aid), and • Reapplies for Medi-Cal alleging that disability continues to exist, and • Is not currently in receipt of SSA/SSI disability benefit.</td>
<td>• Complete a LIMITED packet, or • Complete a FULL packet. Note: See instructions for Limited or Full packets. [Section 32.4]</td>
<td>Eligibility cannot be established: • Until DDSD decision is received, or • Until client has established linkage under another category.</td>
</tr>
</tbody>
</table>
**27.52.3 Reevaluation Referral Procedures**

The reevaluation procedures are as follows:

<table>
<thead>
<tr>
<th>Referral Sent When...</th>
<th>What to Include:</th>
<th>Eligibility Status Pending Reevaluation</th>
</tr>
</thead>
<tbody>
<tr>
<td>EW believes that the DDSD denial is incorrect and it is within 90 days of DDSD's decision.</td>
<td>• Copy of prior MC 221 (note on new MC 221 if not available), SP2 and</td>
<td>Eligibility cannot be established until DDSD completes the reevaluation.</td>
</tr>
<tr>
<td>Examples include:</td>
<td>• A new MC 221 marked “Reevaluation” in Item 8 and state reason for reevaluation in Item 10,</td>
<td></td>
</tr>
<tr>
<td>• DDSD independently reviewed claim and EW believes DDSD was unaware of medical evidence, conditions or recent events which could affect the decision, or</td>
<td>• A new MC 223 or MC 223C (not photocopy of old MC 223/MC 223C) only if additional impairments, condition, or treatment sources are being reported,</td>
<td></td>
</tr>
<tr>
<td>• DDSD adopted an SSA denial and client has a totally new medical condition that was not considered by SSA and the client is not appealing SSA's decision.</td>
<td>• MC 220s for each medical source, and</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Any new medical reports, if available.</td>
<td></td>
</tr>
</tbody>
</table>
27.53 Failure to Cooperate

If the client does not respond or fails to cooperate with the EW's request to complete a new DDSD packet for a required reexamination, follow the steps below:

| Determine eligibility for Medi-Cal under another linkage factor (i.e., AFDC-MN). |
|---|---|
| **If a linkage factor...** | **Then** |
| Exists, | • Transfer Medi-Cal to the new linkage.  
• Continue Medi-Cal eligibility under the appropriate non-ABD Aid Code.  
• Issue a 10 day Notice of Action (NOA), if an increase in share-of-cost results. |
| Does not exist, | Discontinue Medi-Cal following the “Failure to Cooperate” procedures. [Refer to “Denial or Discontinuance Due to Lack of Information, Noncooperation or Loss of Contact [50165 and 50175],” page 7-1]. A 10 day NOA is required. |

27.54 Reexaminations on Appealed DDSD Denials

A Medi-Cal applicant has the right to appeal a DDSD “denial of disability” decision. If the appeal is successful, the applicant, if otherwise eligible, is granted Medi-Cal benefits. The basis for linkage to the Medi-Cal program is the state hearing decision determining that the individual is, in fact, disabled. Document the hearing decision in CalWIN and scan a copy of the decision in the IDM system.

State hearing decisions do not, however, establish whether or not a disability reexam is necessary and, if so, when it will be scheduled. To correct this, the Department of Health Care Services has established the following procedures:
Presumptive Disability (PD) decisions allow applicants/beneficiaries with specific Medi-Cal conditions to be temporarily granted Medi-Cal pending a formal determination by DDSD or Social Security.

- PD categories and verification requirements are established according to federal regulations.

- Social Security Administration (SSA) can grant SSI Title XVI (but not SSA benefit Title II) to an individual based on PD. When an applicant provides verification that SSA allowed SSI-PD, county staff may activate the individual on MEDS and/or issue Medi-Cal card per client’s request. [Refer to “Presumptive SSI and Extended Medi-Cal”, page 9-10]

If retroactive onset date is requested AFTER DDSD has adopted an SSI-PD decision, a limited packet should be sent to DDSD if the final federal decision is favorable (i.e., determined disabled). Item 10 of the MC 221 must be annotated
that “a retro onset date is needed and that SSI has been allowed since PD decision.” There is a possibility that the individual’s determined disability onset date is earlier than the month that the SSI-PD was granted.

• DDSD may grant PD on a case that meets their medical severity criteria and may grant PD outside the PD categories. ONLY DDSD or Social Security can authorize PD for medical conditions not listed on the PD condition list.

• The EW must make a complete DDSD referral within ten days of receipt of the completed “Applicant’s Supplemental Statement of Facts For Medi-Cal” (MC 223) or “Supplemental Statement of Facts for Medi-Cal Child Applicant Only - Under Age of 18: (MC223C). [Refer to “DDSD — Disability Evaluation Forms,” page 29-1] and [Refer to “DDSD — EW Procedures,” page 30-1.]

**PD Criteria**

The EW may approve Medi-Cal based on presumptive disability when ALL of the following criteria is met:

• The client has a Presumptive Disability condition. [Refer to “Presumptive Disability (PD) Categories,” page 27-95.]

• The condition is verified by a doctor/medical source.

• There has not been a Social Security (Title II or SSI) disability denial in the past 12 months (unless a new medical condition is alleged which was not previously considered by the Social Security Administration.

• The client is not performing Substantial Gainful Activity (SGA).

• The client is otherwise eligible for Medi-Cal.

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**27.56 Effective Date**

Presumptive Disability (PD) is:
• Granted prospectively only.

The EW must NEVER grant PD for any past month (i.e., Retro Medi-Cal). Retroactive Medi-Cal can be approved later once the disability onset date is known.

• Approved as of the month that the MC 221 is completed and the medical verification is obtained.

PD Medi-Cal is granted effective the month in which the determination is made that the disabling condition meets the PD requirements. Do not grant PD from the month of application, unless the required Medi-Cal verification and the MC 221 are completed in the month of application.

• Granted only AFTER the client has been determined otherwise eligible for Medi-Cal (e.g., property eligible, etc.).

27.573 Month Retro

Presumptive disability does NOT apply to 3-month retroactive Medi-Cal. The purpose of presumptive disability is to enable patients to receive immediate medical care, not to expedite payments to providers for prior month medical treatments. Once an DDSD approval is received, 3-month retro can be granted if otherwise eligible for Medi-Cal. Under no circumstance is the EW to grant PD for past months.

27.58 Federal Denial

If a DDSD applicant has had a Social Security Title II (RSDI) or Title XVI (SSI) disability 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 or until the decision is changed by Social Security (i.e., decision is changed through the Social Security appeal process). In such cases, the EW must not grant presumptive disability unless the client alleges a new condition which was not previously considered by the Social Security Administration (SSA).
[Refer to “Disability Determination Service Division (DDSD) Referral Limited by SSA Decision,” page 27-9 for additional information regarding DDSD Referrals and Social Security disability decisions.] and [Refer to “Disability Determination Service Division (DDSD) Decision Chart,” page 27-15 for the appropriate DDSD referral action.]

27.59 Presumptive Disability (PD) Categories

Note:
Any condition which does not exactly match a category listed below is not to be granted presumptive disability without prior authorization from DDSD. [Refer to “Urgent Case Request,” page 27-104.]

In order to be determined presumptively disabled, the applicant/beneficiary must provide the county with a medical statement from his/her physician verifying one of the following conditions:

1. Reserved for future use.

2. Amputation of leg at the hip.
   
   Persons with a leg amputated at the hip are unable to wear a prosthesis and thus must use two crutches or a wheelchair.

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 long-standing condition excluding recent accident and recent surgery.
   
   The length of time that the bed confinement or immobility will last must be evaluated. Persons who are convalescing and expected to improve are not presumptively eligible.
6. Allegation of stroke (cerebral vascular accident) occurring more than three months in the past and continued marked difficulty in walking or using a hand or arm.

A three-month delay in evaluating the applicant's condition is required by federal law, as improvement in the individual's condition may occur during this period. DDSD cannot process the disability case until that three-month delay is completed. (NOTE: The three-month period begins the date of the stroke, not the application date.)

Forward the disability packet to DDSD as usual. DO NOT hold the packet for the three-month period. DDSD must delay case processing until three months after the stroke. While presumptive disability is also delayed until the expiration of the three-month period, once that period has expired, the EW shall grant presumptive disability back to the date of application, provided that the applicant is still having 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. Reserved for future use.


Note:

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

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:
• Attends (or attended) a special school, or special classes in school, because of his or her mental deficiency, or is unable to attend any type of school (or if beyond school age, was unable to attend), and

• Requires care and supervision of routine daily activities (i.e., the client is dependent upon others for personal needs which is grossly in excess of what would be age-appropriate).

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 has not attained his or her first birthday and the birth certificate or other evidence (e.g., hospital admission summary) shows a weight below 1200 grams (2 lbs. 10 oz.) at birth.

A disabled or presumptively disabled premature newborn who is born in a facility and remains an inpatient for the remainder of the month is in his/her own MFBU beginning with the month of birth rather than in the following month. [Refer to “Family Members in Long Term Care or Board and Care,” page 60-35 for additional information.]

12. Human Immunodeficiency Virus (HIV) infection. EWs may approved PD for a client with HIV whose medical source confirms, on an HIV form (DHS 7035A or DHS 7035C), that the client has specific disease manifestations.

PD is allowed when specific secondary conditions are present. [Refer to “HIV/AIDS Policy,” page 27-99 for complete procedure.]

13. A child has not attained his or her first birthday and available evidence (e.g., hospital admission summary) shows a gestational age at birth with the corresponding birth weight indicated below:

<table>
<thead>
<tr>
<th>Gestational Age (in weeks)</th>
<th>Weight at Birth</th>
</tr>
</thead>
<tbody>
<tr>
<td>37-40'</td>
<td>Less than 2000 grams (4 lbs., 6 oz.)</td>
</tr>
<tr>
<td>36’</td>
<td>1875 grams or less (4 lbs., 2 oz.)</td>
</tr>
<tr>
<td>35’</td>
<td>1700 grams or less (3 lbs., 12 oz.)</td>
</tr>
<tr>
<td>34’</td>
<td>1500 grams or less (3 lbs., 5 oz.)</td>
</tr>
<tr>
<td>33’</td>
<td>1325 grams or less (2 lbs., 15 oz.)</td>
</tr>
</tbody>
</table>
A disabled or presumptively disabled premature newborn who is born in a facility and remains an inpatient for the remainder of the month is in his/her own MFBU beginning with the month of birth rather than in the following month. [Refer to “Family Members in Long Term Care or Board and Care,” page 60-35 for additional information.]

**Note:**

Gestational Age (GA). The age at birth based on the date of conception, may be shown as “GA” and noted in the available evidence, the EW forwards the referral to DDSD for consideration of PD.

14. A physician or knowledgeable hospice official confirms an individual is terminally ill. An individual is considered terminally ill if he or she has a medical prognosis that his or her life expectancy is six months or less. However, if an individual has a medical prognosis of life expectancy of more than six months, an “Urgent Case Request” must be sent to DDSD. DDSD may approve PD on its own. [Refer to Section 33.13.1 for more information.]

PD is granted to all terminally ill individuals whether they are receiving hospice services or not.

15. Allegation of inability to ambulate without the use of a walker or bilateral hand held assistive device for more than two weeks following a spinal cord injury with confirmation of such status from an appropriate medical professional.

16. End stage renal disease with ongoing dialysis and the file contains a completed “End Stage Renal Disease Medical Evidence Report-Medicare Entitlement and/or Patient Registration” Form (HCFA-2728) from the applicant’s medical provider. This form is necessary before PD can be approved.

17. Allegation of Amyotrophic Lateral Sclerosis (ALS, Lou Gehrig’s Disease).
27.60 HIV/AIDS Policy

Presumptive disability based on Human Immunodeficiency Virus (HIV) or Acquired Immune Deficiency Syndrome (AIDS) can only be established when the diagnosis is confirmed through laboratory tests or clinical findings and specific secondary conditions are present.

EWs must ensure that specific medical conditions are verified on the “Medical Report - Allegation of HIV Infection” (DHS 7035A or DHS 7035C) before approving Medi-Cal based on presumptive disability.

When an applicant alleges HIV/AIDS but does not meet the specific criteria needed to establish presumptive disability, the EW shall:

- Follow regular DDSD referral procedures, and
- Note in the County Comments Section of the MC 221, “Expedite, need for immediate medical care due to HIV/AIDS”.

27.61 Presumptive HIV/AIDS Procedures

EWs shall follow these procedures to establish “presumptive disability” when a Medi-Cal applicant/recipient alleges HIV/AIDS:

<table>
<thead>
<tr>
<th>STEP</th>
<th>ACTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Complete the “Authorization For Release of Information” (MC 220). Complete the “Appointment of Representative” (MC 306) if a representative is used. NOTE: A beneficiary’s representative may not sign the MC 220 unless the applicant is comatose, incompetent, amnesic or deceased.</td>
</tr>
<tr>
<td>2</td>
<td>Complete the “Medical Report - Allegation of HIV Infection” (DHS 7035A; or DHS 7035C if the applicant is under age 18) as follows: • Check the “Medical Release Information” space at the top of the form. • Enter the doctor’s name in the “Medical Source’s Name” space. • Enter the applicant’s name, SSN, and date of birth.</td>
</tr>
</tbody>
</table>
27.62 HIV/AIDS, Adults (Presumptive Criteria Met)

EWs shall review the completed DHS 7035A to determine if presumptive disability can be established. Approve presumptive disability (PD) only if any of the following combinations of sections and boxes have been completed as indicated below:

<table>
<thead>
<tr>
<th>SECTION</th>
<th>COMPLETED OR CHECKED</th>
</tr>
</thead>
<tbody>
<tr>
<td>B</td>
<td>Either box is checked, and</td>
</tr>
<tr>
<td>C</td>
<td>One or more boxes are checked</td>
</tr>
<tr>
<td>OR</td>
<td></td>
</tr>
<tr>
<td>B</td>
<td>Either box is checked, and</td>
</tr>
<tr>
<td>D</td>
<td>Both Items 1 and 2 are completed as follows:</td>
</tr>
<tr>
<td></td>
<td>- Item 1 must indicate the presence of “repeated manifestations of HIV infection” as listed below; and,</td>
</tr>
<tr>
<td></td>
<td>- One or more boxes in Item 2 are checked.</td>
</tr>
</tbody>
</table>
Important

In all cases, presumptive disability cannot be established unless the medical source's name, address and signature are completed at the bottom of the DHS 7035A, Sections F and G.

Persons who may sign the DHS 7035A include a physician, nurse, or other member of the hospital or clinic staff who is able to confirm the diagnosis of HIV. If the signature is questionable, the EW shall call the provider for verification/clarification before granting presumptive disability.

IF: HIV manifestations listed in Section D includes 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)*.

<table>
<thead>
<tr>
<th>AND the number of episodes of HIV Manifestations in the same 1-year period is:</th>
<th>AND the duration of each episode is:</th>
<th>THEN:</th>
</tr>
</thead>
<tbody>
<tr>
<td>At least 3</td>
<td>At least 2 weeks</td>
<td>Requirement is met</td>
</tr>
<tr>
<td>Substantially more than 3</td>
<td>Less than 2 weeks</td>
<td>Requirement is met</td>
</tr>
<tr>
<td>Less than 3</td>
<td>Substantially more than 2 weeks</td>
<td>Requirement is met</td>
</tr>
<tr>
<td>Unable to determine</td>
<td>Unable to determine</td>
<td>Refer to DDSD</td>
</tr>
</tbody>
</table>

* REMINDER: If there is any question as to whether the manifestation listed is a manifestation of HIV, refer to DDSD. Do not approve “PD”.

Important:

The same manifestations need not be represented in each episode.
27.63 HIV/AIDS, Children, Birth Through Age 17 (Presumptive Criteria Met)

Establish presumptive disability only if any of the following combinations of sections and boxes on the DHS 7035C have been completed as indicated below:

<table>
<thead>
<tr>
<th>SECTION</th>
<th>COMPLETED OR CHECKED</th>
</tr>
</thead>
<tbody>
<tr>
<td>B</td>
<td>Either box is checked, and One or more boxes are checked</td>
</tr>
<tr>
<td>C</td>
<td>IMPORTANT: Item 6 only applies to a child under age 13.</td>
</tr>
<tr>
<td>D</td>
<td>Either box is checked, and Item 1 is completed, and • Birth to age 1: One or more of the boxes in Item 2a are checked, OR • Age 1 through age 2: One or more of the boxes in Item 2b are checked, OR • Age 3 through age 17: At least two of the boxes in Item 2c are checked.</td>
</tr>
</tbody>
</table>

Important

In all cases, presumptive disability cannot be established unless the medical source's name, address and original signature are completed at the bottom of the DHS 7035C, Sections F and G.

Persons who may sign the DHS 7035C include a physician, nurse, or other member of the hospital or clinic staff who is able to confirm the diagnosis of HIV. If the signature is questionable, the EW shall call the provider for verification/clarification before granting presumptive disability.
27.64 EW Grants PD

PRIOR to the EW granting PD, the EW must ensure that:

- The applicant’s medical condition matches the PD category list exactly as defined per Medi-Cal Handbook Section 33.5.

There is no PD category for psychiatric impairments (e.g., depression, anxiety and bipolar disorders). Eligibility Staff should never grant PD based on these medical conditions or grant PD outside the pre-defined PD categories.

- The PD reminder check list is reviewed before sending a disability referral to DDSD. [Refer to “Presumptive Disability (PD) Checklist”, page 33-17]

- The “PD approved” box in Item 10 of the “Disability Determination and Transmittal” (MC 221) is checked. This box must NOT be checked when EWs are requesting DDSD to consider PD on a case or if sending an urgent case request. [Refer to “EW Requests PD Consideration from DDSD (For Urgent Case Requests)”, page 33-12]

- All information used to grant PD (e.g., medical documentation, laboratory results, etc.) is included in the disability packet before sending it to DDSD. [Refer to “Procedures for Urgent Case Request”, page 33-14]

- Disability packets are not faxed to DDSD when the EW has already granted PD.

27.65 EW Requests PD Consideration from DDSD (For Urgent Case Requests)

When an applicant does not meet any of the PD categories but meets the criteria for an urgent case requests, the following guidelines apply:

- The District Office DDSD Liaisons must fax the disability packet to the Medi-Cal Program Coordinator (MPC). Since urgent case requests are time-sensitive, the MPC must be notified via email or phone immediately. [Refer to “Procedures for Urgent Case Request”, page 33-14]
Item 10 “PD approved” box of the MC 221 must NOT be checked [Refer to “Procedures for Urgent Case Request”, page 33-14].

27.66 Urgent Case Request

In limited situations, an EW may make an urgent case request to DDSD when they encounter a client who:

- Is in dire need of an immediate disability decision because of a disabling condition which prevents work activity for 12 months or longer, and

- Cannot wait for a formal decision because the delay will cause significant problems to his/her functioning and well-being.

The doctor/medical facility must be willing to support the client’s statement of urgent need by supplying the county with medical records which verify the severity of the client’s condition.

Prior to submitting an Urgent Case Request, the EW must screen the case for presumptive disability criteria and ensure that the client is otherwise eligible (i.e., does not exceed property limit, is not performing SGA).

Note:
A PD/Urgent Case request should not be initiated for an individual who is currently getting medical treatment unless immediate aggressive therapy is needed or a required special medical procedure cannot be done without a Medi-Cal coverage.

27.66.1 DDSD Criteria to Grant PD for Urgent Case Requests

DDSD may grant presumptive disability once certain criteria are evaluated and available evidence shows a strong likelihood that:

- Disability will be established when complete evidence is obtained, and

- 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.
## 27.67 Procedures for Urgent Case Request

The EW shall follow these procedures when an urgent case request is received:

<table>
<thead>
<tr>
<th>STEP</th>
<th>WHO</th>
<th>ACTION</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>EW</td>
<td>Has applicant or his/her authorized representative complete the application and DDSD packet.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Screens case for presumptive disability criteria and clears all other aspects of eligibility, including property and income.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Asks doctor/medical facility for faxed medical reports to verify the severity of medical condition (i.e., hospital admission, outpatient progress reports, X-ray reports, pathology reports, laboratory studies, etc.).</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Enters in Item 10 of the MC 221:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>&quot;Urgent Case Request - Please Evaluate for Presumptive Disability&quot;, and</td>
</tr>
<tr>
<td></td>
<td></td>
<td>&quot;Attention: Operations Support Supervisor&quot;.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Note: &quot;PD approved&quot; box in Item 10 of the MC 221 must NOT be checked.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Enters EW’s FAX number in Item 11 of the MC 221.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Gives the completed packet (FULL packet) to appointed District Office DDSD screener to review for completeness.</td>
</tr>
<tr>
<td>2</td>
<td>District Office DDSD Liaison</td>
<td>Faxes the urgent case DDSD packet to the Medi-Cal Program Coordinator.</td>
</tr>
<tr>
<td>3</td>
<td>EW</td>
<td>Mails the original DDSD packet, including the medical reports to the DDSD office in Oakland.</td>
</tr>
<tr>
<td>4</td>
<td>Medi-Cal Coordinator</td>
<td>Faxes the DDSD packet and medical reports to the DDSD office.</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Phones DDSD to tell them an Urgent Case Request was faxed.</td>
</tr>
</tbody>
</table>
Note:
EW must not delay sending a DDSD packet if medical reports have not been received. Medical reports can be faxed to DDSD later with a DDSD Pending Information Update (MC 222) as soon as they are received. Indicate in Item 10 of MC 222 “Urgent Case Request. Medical reports attached. Packet sent on (date)."

### 27.68 Examples of Situations Requiring Urgent Case Request

1. 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 the client is expected to survive, he/she is expected to be dependent on a wheelchair for the rest of his/her life.

2. A client has lung cancer which has spread to the spine and vital organs. The doctor states he/she is expected to live 6 to 12 months, even with treatment, and needs aggressive therapy immediately.
3. Client has irreversible kidney failure caused by uncontrolled high blood pressure and is now on renal dialysis. Hospital records and the doctor’s outpatient notes include lab studies which confirm that the kidney function has decreased over the past year and dialysis is required for the client to survive. An immediate Medi-Cal decision is necessary to transfer the client to an outpatient renal dialysis clinic.

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

### 27.69 Follow-Up/Expediting Decisions

Even though eligibility has been granted, a full DDSD referral must be completed when an applicant is presumptively determined to be disabled. [Refer to “DDSD — Disability Evaluation Forms,” page 29-1] and [Refer to “DDSD — EW Procedures,” page 30-1 for DDSD referral forms and procedures.]

Whenever immediate medical care is indicated:

- Note that the case needs to be expedited on the MC 221 in the Comments Section.

- Submit medical records with the DDSD packet if they are available. Do not hold up the referral pending receipt of medical records.

### 27.70 Verification Requirement

The applicant/beneficiary must provide the EW with a medical statement from his/her physician verifying one of the Presumptive Disability Conditions. The medical statement must be:

- Signed and dated by a doctor and include his/her title, and
- Included with the DDSD packet.
Note:
If there is a delay in obtaining verification from the applicant or medical source and the EW cannot grant PD, DO NOT hold the DDSD referral packet. The EW must forward the referral packet to DDSD, as DDSD can also grant PD.

27.71 Presumptive Disability (PD) Checklist

Use the Presumptive Disability (PD) checklist below to help ensure accurate PD determinations and referrals.

• Does the client’s impairment exactly match an impairment on the PD condition list? If so, does the MC 221 - Item 10 have the following information:
  • “PD approved” box checked, and
  • The specific medical condition used to grant PD.

• Has there been a prior SSA/SSI denial within the past 12 months? If yes, PD can only be approved if the client alleges a new medical condition that exactly matches a PD condition which SSA did not previously consider.

• Is there a signed and dated verification of the disability/impairment from the applicant’s physician/medical source? Is a copy included with the DDSD packet?

• Is the client otherwise eligible for Medi-Cal (e.g., property, etc.)? If no, a disability referral is not necessary since other Medi-Cal requirements are not met.

• Is the client performing SGA? If yes, PD cannot be granted and a disability referral is NOT appropriate.

• Submit the DDSD packet immediately. Do not delay sending the packet if medical verification is lacking or delayed. DDSD can initiate a PD determination if the medical evidence supports it.

• Is the PD effective date the month in which the MC 221 is completed and the medical verification obtained?
  • The EW must NEVER grant PD for any past month.
  • Do not grant PD from the month of application, unless the required Medi-Cal verification and the MC 221 are completed in the month of application.