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February 6, 1995

MEDI-CAL ELIGIBILITY PROCEDURES MANUAL LETTER NO. 142

TO: All Holders of the Medi-Cal Eligibility Procedures Manual

MEDI-CAL ELIGIBILITY PROCEDURES ON DISABILITY

REVISIONS TO THE MEDI-CAL ELIGIBILITY PROCEDURES MANUAL

Enclosed are revisions to Article 22 of the Medi-Cal Eligibility Procedures Manual pertaining to disability which were released in Medi-Cal Eligibility Procedures Manual Letter No. 132 on May 27, 1994. These revisions primarily update, correct, or clarify information previously provided in Procedures Manual Letter No. 132.

As indicated in E-Mail EMC2 DHS No. 94169 dated November 28, 1994, Article 22 procedures will be implemented no later than February 1, 1995.

The revisions in this Procedures Manual Letter are specified and described as follows:

22C-1: Referring Disability Applications to Social Security Administration (SSA) or State Programs-Disability Evaluation Division (SP-DED)

22C-1.2	Item B identifies situations when county welfare departments (CWDs) can rescind a prior Medi-Cal denial when SSA approves disability after originally denying the claim.
22C-1.6	Updates SSA/SP-DED Client Referral Chart due to renumbering of questions pertaining to an SSA disability application on the June 1994 revision of the MC 223.

22C-2: Determining Substantial Gainful Activity (SGA)

22C-2.1	Item 3A.1 eliminates reference to SGA computation of vacation or sick pay received within six months of discontinuing work activity.
22C-2.7 to 2.8	Item D identifies unsuccessful work attempt situations when client discontinues work due to an impairment after returning to work for short periods of time.
22C-2.8a	Item E directs CWD to include 1) copy of SGA Worksheet (MC 272) in disability packet or 2) comment in Item 10 of MC 221 regarding evaluation of earnings for SGA.

22C-3: Determining Presumptive Disability (PD)

22C-3.1	Item 1, second paragraph specifies that PD is granted as of the current month in which <u>verification</u> is obtained, rather than the month of discovery of the disabling condition.

22C-4: Completing Disability Evaluation Forms

22C-4.2	Item D.2 specifies that SP-DED uses a form letter (LAX 9/OX 9) to inform CWD that an MC 179 needs to be sent to client.
22C-4.6	"<u>NOTE</u>" specifies that if a packet is transferred to another Branch, a box at the bottom of MC 221 will inform CWD about location of case.
22C-4.7 to 4.11	Provides instructions for revised MC 223 (6/94). Part II on page C-4.8 directs CWD to issue denial Notice of Action (NOA), MC 239 SD (3/92) and MCIN 13 (3/92) when client is referred back to SSA.
22C-4.11a	Provides instructions for MC 239 SD and MCIN 13.
22C-4.21 to 4.26b	Provides example of MC 223 (6/94).
22C-4.26c to f	Provides example of denial NOA, MC 239 SD (ENG/SP).
22C-4.26g to h	Provides example of MCIN 13 (ENG/SP).

22C-6: Assembling and Sending SP-DED Packets

22C-6.2	Under "SSA Documents", emphasizes need to obtain a copy of client's notification of benefits/denial, especially the personalized denial notice.
22C-6.6	Emphasizes the need to send completed disability packet to SP-DED while other non-disability factors are being verified.

22C-7: Communicating with SP-DED and DHS About Changes and Status

22C-7.1	Provides FAX numbers for Los Angeles (LA) and Oakland Branches.
22C-7.2	Item A reflects a change of LA Branch's contact person; Item C updates telephone numbers for Masterfiles in both Branches.

22C-8: Processing SP-DED Decisions

22C-8.5	Eliminates the "under 30 days " and "over 30 days" provision for resubmitting packets to SP-DED if good cause exists.

22D: Disability Evaluation Division Procedures

22D-3	Specifies that SP-DED sends an informational form SPB 101 to CWD which provides the reason(s) for a medical deferment.

ACTION REQUIRED

Remove Pages	Insert Pages
Article 22 Table of Contents Pages 1 through 5	Article 22 Table of Contents Pages 1 through 5
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Glossary	Glossary
22C-1.1 through 22C-1.6	22C-1.1 through 22C-1.6
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22C-8.5	22C-8.5
22D-3	22D-3

If there are any questions regarding these procedures, please contact Ms. Pat Takahashi of my staff at (916) 657-1246.

Sincerely,

Frank S. Martucci

Frank S. Martucci, Chief
Medi-Cal Eligibility Branch

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GLOSSARY OF ACRONYMS

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

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

1. BACKGROUND

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

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

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

2. FEDERAL DISABILITY EVALUATION BY SSA

A. Guidelines For Referring Client To SSA

SSA refers case to FP-DED for a disability evaluation in the following situations. (Refer to SSA/SP-DED chart at the end of this section to determine when to refer client to SSA.)

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

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

SSA Denied Claim More Than One Year Before The Current Date

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

B. Special Handling of Federal Decisions

The following specifies situations when CWD can rescind a prior Medi-Cal denial, after following the 1990 Regulations which require that a Medi-Cal application be denied and client referred back to SSA.

SSA Approves Disability After Originally Denying Claim

CWD will RESCIND prior Medi-Cal denial and approve Medi-Cal, if otherwise eligible. New application or referral to SP-DED not needed if SSA's disability onset date coincides with request for Medi-Cal coverage.

If retro Medi-Cal is needed, send full packet. Include SSA award letter. In item 5 of MC 221, indicate initial Medi-Cal application date (before client was referred to SSA) to protect client's original filing date and specify "client was originally denied and referred to SSA for reopening" in Item 10 (Comments section) of MC 221.

NOTE: Request for retro onset must be made within one year of the month for which retroactive coverage is requested.

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

The following are guidelines for determining who should and should not be referred to SP-DED for a Medi-Cal disability evaluation. (Refer to SSA/ SP-DED chart at the end of this section to determine when to refer claim to SP-DED after/during SSA's decision on a disability claim.)

A. Who Should NOT Be Referred To SP-DED

Incapacity Or Pregnancy Verification	Do not refer clients to request verification of incapacity or pregnancy
Prior SP-DED Decision - Disabled	Do not refer client who has had a decision made within the past 12 months unless the reexamination date has passed, or there is an indication that the medical condition has improved.
Prior SP-DED Decision - Not Disabled	Do not refer client who has had a claim denied within the past 90 days. Client should be advised of the appeal process. However, if CWD believes that the SP-DED denial is incorrect, the case may be sent back for a reevaluation within 90 days, as discussed in C-9.
Other Factors Causing Ineligibility	Do not refer client who **CLEARLY** does not meet other eligibility factors, such as state residence or resource limits, or if there are questions about other verifications. Otherwise, if DED packet is complete, send it while other eligibility factors are being verified.
Refusal To Be Evaluated	Do not refer client who refuses to be evaluated, as any client has the right to refuse to be evaluated for a disability. CWD should discuss the possibility of a disability referral with clients who appear to be disabled but who have not requested a disability evaluation. *Example: Client is confined to a wheelchair, or has difficulty walking, standing or sitting; the individual seems disoriented, or shows extreme emotional distress.*
Prior SSA Decision-Not Disabled	Do not refer clients to SP-DED who were denied disability status by SSA: 1. Within 60 days: refer to SSA for a reconsideration.

2. Within 12 months: client alleges same condition worsened; does not allege a new condition; did not ask SSA to reopen claim.

3. More than one year ago: client does not allege the same condition has worsened or that there is a new condition.

4. At any time: when client appealed denial and decision on appealed claim is pending.

B. Who SHOULD BE Referred To SP-DED

No Prior SSA Evaluation	Client's disability has never been evaluated by SSA.
SSA Application Status Is Unknown Or Pending	Client's application for RSDI (Title II) or SSI (Title XVI) is pending or client does not know status of claim.
SSA Application Denied Because of Excess Income/Resources	Client's application for SSI is denied for excess income/resources and client has proof of such, and client meets income/resource requirements for Medi-Cal.
SSA Approved Claim	SSA has set a specific onset date as the start of disability, and client is requesting retroactive Medi-Cal coverage prior to that onset date.
SSA Denied Claim	1. SSA denied claim within 12 months, alleges new condition not considered by SSA, has not reapplied with SSA. 2. SSA denied claim over 12 months ago, same condition worsened, has not reapplied with SSA. 3. SSA denied claim over 12 months ago, has new condition not considered by SSA, has not reapplied with SSA.

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

SSA/SP-DED CLIENT REFERRAL CHART

Items 5 to 5D of the MC 223, Applicant's Supplemental Statement of Facts For Medi-Cal, identify whether client has applied for Social Security or SSI disability benefits in the past two years. Client's responses determine whether a disability claim is referred to SSA or SP-DED. The following chart helps to identify where the claim should be referred.

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

10/1/94

22 C-2 -- DETERMINING SUBSTANTIAL GAINFUL ACTIVITY

1. BACKGROUND

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

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

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

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

2. WHEN TO USE THESE PROCEDURES

These procedures will be used when a client:

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

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

3. PROCEDURES

A. SGA DETERMINATIONS

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

1. *Obtain*: Client's gross monthly earnings (if irregular, earnings should be averaged). Earnings derived from In-Home Supportive Services are treated as earned income.
2. *Determine*: Whether there are impairment-related work expenses (IRWEs) or subsidies that can reduce earnings below $500. (A discussion of IRWEs and subsidies follows.)
3. *Deny*: Claim if "net countable earnings" are over $500.

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

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

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

B. IMPAIRMENT-RELATED WORK EXPENSES

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

1. $500 SGA Determination

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

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

2. Allowable IRWE Deductions

Deductions are allowed when the following conditions exist:

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

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

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

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

3. Budgeting of IRWE

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

a. Recurring and Non-Recurring IRWEs

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

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

b. Cost Incurred Before or After Work

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

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

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

4. IRWE Categories

DEDUCTIBLE	*NON DEDUCTIBLE*
Attendant Care Services	*Attendant Care Services*
• Performed in work setting or in process of assisting in preparations for work, the trip to/from work and after work (e.g., bathing, dressing, cooking, eating).	• Performed on non-workdays or involving shopping or general homemaking (e.g., cleaning, laundry).
• Services which incidentally benefit the family (e.g., cooking meal for individual also eaten by family).	• Services performed for someone in the family other than the beneficiary (e.g., babysitting).
• Services performed by a family member for a cash fee where the family member suffers an economic loss by reducing or terminating work to perform such services.	• Services performed by a family member for a cash fee where the family member suffers no economic loss.
• Requires verification of duties, of amount of time spent, that they were paid for in cash, and that payment is made on a regular basis.	
Transportation Costs	*Transportation Costs*
• Structural or operational modifications to vehicle, needed to drive to work or be driven to work, even if also used for non-work purposes.	• Cost of a vehicle whether modified or not.
• Driver assistance or taxicabs where such special transportation is not generally required by unimpaired individuals in the community.	• Cost of modification to a vehicle not directly related to the impairment or critical to the operation of the vehicle (e.g., paint or decor preferences).
• Mileage expense limited to travel related to employment.	• Cost of travel related to obtaining medical items or services.

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

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

C. SUBSIDIES

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

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

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

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

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

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

D. SPECIAL WORK CONSIDERATIONS

If client is forced to stop working after a short time due to an impairment, the work is generally considered an unsuccessful work attempt (UWA) and earnings from that work will not show ability to do SGA.

1. UNSUCCESSFUL WORK ATTEMPT (UWA) REQUIREMENTS

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

- there is a break in client's employment of 30 days or more, and
- work lasted less than six months, and
- work stopped due to client's impairments.

2. EVALUATING UNSUCCESSFUL WORK ATTEMPTS

The following are examples of possible situations which might be encountered when evaluating work activity. How the EW analyzes the situation and what action the EW takes are also provided below.

***EXAMPLE A**: Client worked from 12/1/92 to 6/30/94. Work stopped due to his impairment. He returned to work on 8/5/94 and stopped again on 9/1/94. He applied on 9/2/94 with a request for retro back to 7/94.*

EW's Analysis

- There is a break in employment of over 30 days between 6/30 and 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 6/94 is an UWA".
- In Item 6 of MC 221, list retro months of 7/94 and 8/94.

***EXAMPLE B**: Client worked sporadically from 10/93 to 12/93, 3/94 to 4/94 and 6/94 to 7/94 because of his mental illness. He applies on 7/10/94, asking for retro back to 4/94.*

EW's Analysis

- There is a break in employment of over 30 days between each work period.
- Work lasted less than six months for each employment period.
- Work stopped due to client's impairment.

EW's Actions

- In Item 10 of MC 221, indicate "work prior to application is an UWA".
- In Item 6 of MC 221, list retro months 4/94, 5/94 and 6/94.

***EXAMPLE C**: Client worked until 5/30/94 and applied on 7/7/94, requesting retro onset to 4/94. CWD determined that client was engaging in SGA in 4/94 and 5/94. In Item 6 of MC 221 that was sent to SP-DED, EW Indicated "6/94", and indicated in Item 10 "client engaged in SGA in 4/94 and 5/94". On 8/31/94, client reports a return to work for 8/94 only, but stopped because of her impairment.*

EW's Analysis

- There is a break in employment over 30 days from 5/30 and 8/1.
- Work in 8/94 lasted less than six months.
- Work stopped due to client's impairment.

EW's Actions

- Complete and send MC 222, DED Pending Information Update form to SP-DED.
- Indicate in Item 9 that client's return to work in 8/94 was an UWA, and that client is no longer working.

E. NOTIFICATION

1. Notifying SP-DED

If CWD has evaluated client's earnings for SGA, CWD should include a copy of the SGA Worksheet (MC 272), or provide the necessary information in Item 10 ("Comments" Section) of the MC 221.

If CWD has already sent the disability packet to SP-DED, and an SGA issue has been clarified, SP-DED should be informed of the evaluation of client's work activity via an MC 222, DED Pending Information Update form.

2. Notifying Client

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

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

NOTE: The Title 22 reference section is: 50224

F. FORMS

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

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

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

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

Include copy of MC 272 (or other worksheet of CWD choice) in disability packet, and indicate in Item 10 of MC 221 what the results were regarding CWD's evaluation of client's earnings.

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

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

3. DED Pending Information Update, Form MC 222:

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

22 C-3 -- DETERMINING PRESUMPTIVE DISABILITY

1. BACKGROUND

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

Presumptive Disability is granted as of the current month in which verification of the disabling condition is obtained. PD is NOT allowed for retroactive months.

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

2. RESPONSIBILITIES OF CWD AND SP-DED

A. CWD

1. *Medical Statement Provided*

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

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

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

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

2. *If SP-DED Grants PD*

   CWD should immediately process case and grant PD.

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

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

B. SP-DED

1. *CWD Notification*

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

2. *MC 221*

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

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

3. *Formal Decision Made*

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

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

22 C-4 -- COMPLETING DISABILITY EVALUATION FORMS

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

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

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

A. BACKGROUND

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

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

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

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

B. COMPLETING THE MC 179

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

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

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

- For you to contact your eligibility worker RIGHT AWAY because your disability form(s) is not completed correctly; and

- Other. (Specify reason(s) in space provided.)

C. WHEN THE MC 179 IS USED

County MUST issue MC 179 in the following situations:

1. No later than the 80th day from date Medi-Cal based on disability is requested, if disability packet has not been submitted to SP-DED, or

2. At any time prior to the 80th day if CWD knows that the packet will not be sent by the 80th day, or

3. If on the 80th day, CWD has a returned SP-DED referral packet, or

4. If CWD received a letter from SP-DED that the MC 179 was missing when SP-DED received the referral packet on the 86th day or later. Attach copy of MC 179 sent to client to a copy of SP-DED's letter with the comment "see attached" on SP-DED's letter, and send to SP-DED.

D. SEND COPY OF MC 179 TO SP-DED

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

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

2. Attach copy of MC 179 to copy of SP-DED's form letter (OX 9 from Oakland Branch or LAX 9 for LA Branch) which informed CWD that case was received by SP-DED after the 86th day without a copy of the MC 179 included. Enter comment "see attached" on copy of SP-DED's letter.

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

A. HOW THE MC 220 IS USED

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

B. ONE MC 220 PER TREATING SOURCE

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

C. HOW TO COMPLETE THE MC 220

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

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

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

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

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

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

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

D. SIGNATURE REQUIREMENTS

The MC 220 may be signed by:

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

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

Special considerations on handling MC 220s are as follows:

1. Client Has A Guardian Or Conservator

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

2. The Client Is Incompetent Or Physically Incapable of Signing

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

3. The Client Can Only Sign With A Mark

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

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

E. AUTHORIZED REPRESENTATIVE (AR) FORM IN FILE

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

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

4. MC 221 -- DISABILITY DETERMINATION AND TRANSMITTAL

A. USE OF FORM

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

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

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

B. HOW TO COMPLETE THE MC 221

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

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

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

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

Item 8: Check all applicable boxes.

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

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

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

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

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

NOTE: If SP-DED forwarded a packet to another Branch to "equalize" its caseload, a box at the bottom of form ("Oakland" or "LA") will be checked to specify the Branch to which jurisdiction was transferred. A copy of the MC 221, with one of the boxes checked, will be sent to CWD by the receiving Branch ONLY if a case is "equalized". This alerts CWD that the case is assigned to a Branch other than the one to which a packet was sent.

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

A. USE OF FORM

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

B. CHANGES TO REPORT TO SP-DED

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

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

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

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

A. IMPACT OF SSA'S DECISION

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

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

B. QUESTIONS WHICH PERTAIN TO AN SSA DECISION

Questions 5 through 5D help CWD decide whether to deny an application for Medi-Cal based on disability and refer client to SSA, or whether to refer client to SP-DED for an independent disability decision.

C. HOW TO COMPLETE THE MC 223

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

Parts I and II below, Personal and Medical Information, should be completed by client as much as possible. Any corrections should be initialed. CWD staff should write any information which may be helpful for case processing in margin designated as "County Use Only".

PART 1 - PERSONAL INFORMATION

Item 1a Provide full name.

Item 1b Include Social Security Number. If none exists, indicate "Pending" on "N/A" (applies to all cases). DO NOT leave blank.

Item 1c Specify month, day AND year of birth.

Item 1d Provide all known alias(es).

Item 1e Specify if male or female.

Item 1f-g Provide height in feet and inches, and weight in pounds.

Item 2a-b Provide residence address. Specify mailing address if different.

Item 3 Provide area code and phone number. Indicate if there is no phone or if there is a message number. Specify best time to call.

Item 4a-b Indicate if English is spoken; if not, specify language spoken. If interpreter is available, indicate name, phone number and best time to call.

PART II - MEDICAL INFORMATION

Item 5 Indicate if client applied for Social Security or Supplemental Security Income (SSI) disability benefits within the past two years.

NOTE: CWD will review client's responses to Items 5-5d.

- If "no", submit disability packet to SP-DED.
- If "yes", consider the following questions on client's SSA disability claim:
  - did SSA approve claim?
  - did SSA deny claim or is status unknown or pending?
  - was decision made within or more than 12 months of the Medi-Cal application?
  - was SSA's denial appealed?
  - has client's condition worsened or have new medical problems developed?
- If "yes", refer to the following chart which specifies whether case should be referred to SSA or SP-DED. If client is referred to SSA, CWD will deny the disability application and issue denial NOA, MC 239 SD (3/92), and Important Information Regarding Your Appeal Rights - Social Security Information, MC Information Notice 13 (3/92).

SSA/SP-DED CLIENT REFERRAL CHART

Items 5 to 5D of the MC 223, Applicant's Supplemental Statement of Facts For Medi-Cal, identify whether client has applied for Social Security or SSI disability benefits in the past two years. Client's responses determine whether a disability claim is referred to SSA or SP-DED. The following chart helps to identify where the claim should be referred.

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

Item 6 Indicate all medical problems that prevent work activity or limit daily activities. Specify when they started and attach additional pages if needed.

Items 7-8 Indicate any CLINIC OR HOSPITAL where treatment was received in last 12 months. Enter COMPLETE name(s) and address(es), including zip codes. Include current phone numbers including area codes. Enter patient, clinic or member numbers when applicable. (If treatment received at additional clinics or hospitals, complete page 8.) Complete MC 220 (7/93) for every treating source identified. Check box in county use margin to ensure that MC 220s have been completed.

NOTE: CWD will state if information is unobtainable despite diligent efforts on address line or in right margin, or it will appear that it was inadvertently omitted. DO NOT leave blank.

Item 9 Specify any DOCTOR seen OUTSIDE OF the clinics or hospitals listed in items 7-8, including one who is out of county/state. Enter COMPLETE name and address including zip codes, and current phone number with area code. Complete MC 220 (7/93) for every treating source identified. Check box in right margin to ensure that MC 220s have been completed.

NOTE: CWD will state if information is unobtainable despite diligent efforts on address line or in right margin, or it will appear that it was inadvertently omitted. DO NOT leave blank.

Item 10 Enter all testing performed and give COMPLETE name/address of facility and date of test. If others were performed but names are unknown, enter "unknown test" in "Other". Complete MC 220 (7/93) for every treating source, if not identified previously in items 7-9.

Item 11 If additional treatment was received or testing performed in last 12 months, complete page 8. Complete MC 220 (7/93) for every treating source, if not identified previously in items 7-9.

NOTE: CWD will check box in right margin to ensure that MC 220s have been completed.

Item 12 List third party sources who know about the medical condition(s), as SP-DED may need to contact them.

Item 13 Indicate willingness to go to additional medical examinations which may be needed and which will be paid by the state.

PART III - SOCIAL AND EDUCATIONAL INFORMATION

Item 14 Indicate what daily activities are participated in and how they are affected by the medical condition(s). This is helpful to SP-DED, especially in mental or emotional disorders.

Item 15a-c Indicate highest grade or if GED completed, when it was completed, or if special education classes were involved.

NOTE: CWD will indicate any inconsistency noticed by notating it in right margin or in "Comments" section of MC 221 (e.g., client indicates an eighth grade education but has significant difficulties in reading, writing or understanding).

Item 16 Specify if there was work activity within last 15 years. If "yes", complete Part IV.

PART IV - WORK HISTORY

Item 17 Enter job title, dates worked and job description. If no description is provided, SP-DED will use the job description in the Dictionary of Occupational Titles.

Highlights Of What To Include In Job Description:

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

PART V - SIGNATURE AND CERTIFICATION

- Enter proper signature(s) and current date.

  NOTE: CWD will provide client three extra MC 220s (7/93) for client's signature only.

7. MC 239 SD -- MEDI-CAL NOTICE OF ACTION - DENIAL OF BENEFITS DUE TO A FEDERAL SOCIAL SECURITY DISABILITY DETERMINATION (ENGLISH/SPANISH)

If the following exist, SP-DED is not allowed to make an independent decision and CWD must complete MC 239 SD to notify client that case is denied.

- SSA has denied a disability claim on the same condition(s) which is (are) alleged on the Medi-Cal application based on disability **AND** the application is within 12 months of the SSA denial **AND** client has a worsening of his/her condition.

OR

- The Medi-Cal application based on disability is within 12, or more than 12 months of the SSA denial **AND** client has no changes or new condition(s).

8. MC INFORMATION NOTICE 13 -- IMPORTANT INFORMATION REGARDING YOUR APPEAL RIGHTS/SOCIAL SECURITY INFORMATION (ENGLISH/SPANISH)

This notice is used in conjunction with Medi-Cal Notice of Action, MC 239 SD. It informs client of the following:

- Appeal rights through SSA,
- Information regarding SSA reconsideration/reopening,
- Circumstances in which SP-DED cannot make an independent disability determination,
- Circumstances in which SP-DED is allowed to make an independent disability determination, and
- Circumstances in which client is allowed to file for a state hearing.

9. MC 272 -- SGA WORKSHEET

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

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

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

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

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

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

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

Items 1 to 8 Applicant completes these items.

Item 9 EW indicates if (a) subsidy or (b) IRWE is applied to gross earned income and if applicant is found to be engaging in (c) SGA.

EW indicates in "Explanation" section how a decision of SGA or non-SGA was determined.

11. MC 4033 -- UPDATE TO DISABILITY LIAISON LISTS

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

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

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

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

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

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

13. DHS 7045 -- WORKER OBSERVATIONS - DISABILITY

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

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

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

APPLICANT'S SUPPLEMENTAL STATEMENT OF FACTS FOR MEDI-CAL

COUNTY USE ONLY
County Number/Aid Code/Case Number
— —

PART I—PERSONAL INFORMATION

1a. Applicant name (Last, First, MI)	1b. Social Security number	1c. Date of birth
	— —	/ /

1d. Other name(s) used (Last, First, MI)	1e. Sex	1f. Height	1g. Weight
	☐ Male ☐ Female	Feet ____ Inches ____	Pounds ____

2a. Home address	City	State	ZIP code

2b. Mailing address (if different)	City	State	ZIP code

3. Daytime telephone number	Check if:	Best time to call
(____) _____	☐ No Phone ☐ Message Phone (____) _____	

4a. Do you speak English?	4b. Do you have an interpreter?	If YES, interpreter's name:	Best time to call
☐ Yes If YES, go to Part II	☐ Yes ☐ No		
☐ No If NO, what language(s) do you speak: _____		Interpreter's phone number: (____) _____	

PART II—MEDICAL INFORMATION

COUNTY USE ONLY

5. Have you applied for Social Security Disability or Supplemental Security Income (SSI) Disability benefits in the past two (2) years? ☐ Yes ☐ No

   If YES, please answer the following:

   a. Was/Is your Social Security or SSI Disability application:

      ☐ Approved? ☐ Denied? ☐ Pending? ☐ On Appeal? ☐ Unknown?

   b. If approved or denied, give the date of the most recent decision on your Social Security or SSI disability application:

   c. Has your medical problem(s) worsened since the date in 5b above? ☐ Yes ☐ No

      If YES, please explain: _____

   d. Do you have any NEW medical problem(s) since the date in 5b, above, which you did NOT have when your Social Security or SSI disability decision was made?

      ☐ Yes ☐ No If YES, what medical problem(s)? _____

6. List all medical problems (physical, mental or emotional) that keep you from working or taking care of your personal needs. (Please attach additional sheet, if necessary.)

MEDICAL PROBLEM(S)	WHEN DID IT START (Month/Year)

7. Have you received care in a **clinic** or **hospital** for your illness(es) or injury(ies) in the last 12 months? ☐ Yes ☐ No

If YES, please fully answer the following:

Name of clinic/hospital

Patient/clinic or member number | Clinic/hospital telephone number ( )

Name of doctor(s) seen

ADDRESS of clinic/hospital (number, street, suite) | City | State | ZIP code

Date first seen | Date last seen | Date of next appointment

Reason for the visit(s)

Did you stay in the **hospital** overnight? ☐ Yes ☐ No

If YES, date(s) entered: _____ date(s) left: _____

Were you seen in the **emergency** room? ☐ Yes ☐ No

If YES, date(s) seen: _____

List *ALL* medicines received: _____

List *ALL* treatments received and the dates the treatments were received: _____

COUNTY USE ONLY

MC 220 Signed ☐

8. List any additional **clinic** or **hospital** where you have been seen in the last 12 months.

Name of clinic/hospital

Patient/clinic or member number | Clinic/hospital telephone number ( )

Name of doctor(s) seen

ADDRESS of clinic/hospital (number, street, suite) | City | State | ZIP code

Date first seen | Date last seen | Date of next appointment

Reason for the visit(s)

Did you stay in the **hospital** overnight? ☐ Yes ☐ No

If YES, date(s) entered: _____ date(s) left: _____

Were you seen in the **emergency** room? ☐ Yes ☐ No

If YES, date(s) seen: _____

List *ALL* medicines received: _____

List *ALL* treatments received and the dates the treatments were received: _____

MC 220 Signed ☐

If you have been seen at additional clinics or hospitals in the last 12 months, complete page 8.

9. Have you been seen by any doctor outside of the clinic(s) or hospital(s) you have already listed in the last 12 months? ☐ Yes ☐ No

If NO, go to number 10. If YES, please fully answer the following, if more than one doctor was seen please complete page 8 for all additional information:

Name of doctor(s)

Patient/clinic or member number | Doctor's telephone number ( )

Address of doctor (number, street, suite) | City | State | ZIP code

Date first seen | Date last seen | Date of next appointment

Reason for the visit(s)

List *ALL* medicines received: _____

List *ALL* treatments received and the dates the treatments were received: _____

COUNTY USE ONLY

MC 220 Signed ☐

10. Please list below if you have had any of the following tests in the last 12 months. Be sure to check yes or no next to each test. (IF ADDRESS OF DOCTOR, CLINIC, OR HOSPITAL WAS GIVEN ALREADY, LIST ONLY THE NAME AND DATE.)

TEST PERFORMED	YES	NO	NAME AND ADDRESS OF OFFICE, CLINIC, OR HOSPITAL WHERE TEST WAS COMPLETED	DATE (MO/YR)	
Electrocardiogram (EKG)			Name Address (number, street, suite) City State ZIP Code		MC 220 Signed ☐
Treadmill (exercise heart test)			Name Address (number, street, suite) City State ZIP Code		MC 220 Signed ☐
Chest X-ray			Name Address (number, street, suite) City State ZIP Code		MC 220 Signed ☐
Breathing Test (PFT)			Name Address (number, street, suite) City State ZIP Code		MC 220 Signed ☐
Blood Tests			Name Address (number, street, suite) City State ZIP Code		MC 220 Signed ☐
Other (Specify)			Name Address (number, street, suite) City State ZIP Code		MC 220 Signed ☐

COUNTY USE ONLY

11. Have you had any other medical treatment or testing in the past 12 months? ☐ Yes ☐ No

    If NO, go to number 12.
    If YES, complete page 8.

12. Is there anyone else (a friend, relative, social worker, rehab counselor, attorney, physical therapist, etc.) we may contact for information regarding your illness or injury and how it limits your daily activities or keeps you from working? ☐ Yes ☐ No

    If YES, please list below:

Name	
Address (number, street, suite)	
Telephone number ( )	Relationship to you
Name	
Address (number, street, suite)	
Telephone number ( )	Relationship to you
Name	
Address (number, street, suite)	
Telephone number ( )	Relationship to you

13. You may be asked to go to additional medical examinations to help evaluate your medical problem(s). (These examinations are free to you.)

    Are you willing to go to additional medical examinations if needed? ☐ Yes ☐ No

PART III—SOCIAL AND EDUCATIONAL INFORMATION

14. Describe your daily activities and tell us how much your condition limits your activities.

    _____

    _____

    _____

15. Describe your educational background.

    a. Check the highest grade you finished in school:

    ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐ 11

    ☐ 12 or ☐ GED (same as finishing 12th grade) ☐ 12+

    b. When finished? Month/year: _____

    c. Did you take special education classes? ☐ Yes ☐ No

16. Have you done any type of work for more than 30 days during the last 15 years? (This includes work done in another country.)

    ☐ Yes ☐ No

    If NO, skip Part IV, go to Part V, page 7, for your signature.

    If YES, answer Part IV, page 5, beginning with number 17.

PART IV—WORK HISTORY

COUNTY USE ONLY

17. Describe all of the jobs you have done for at least 30 days during the last 15 years. Start with your most recent job. (If you had more than two jobs, ask your county worker for additional pages.)

a. Job title | Type of business

Dates worked (month/year) | Hours per week | Rate of pay | Per hour/wk/mo

From: _____ To: _____

DESCRIPTION OF THE JOB (This is what I did and how I did it)

_____

_____

_____

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

_____

_____

I took this long to learn the job: _____ day(s) or _____ month(s).

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

I had supervisory responsibilities ☐ Yes ☐ No

PHYSICAL ACTIVITY — **Circle One**

I walked this many hours in an average workday: 0 1 2 3 4 5 6 7 8

I stood this many hours in an average workday: 0 1 2 3 4 5 6 7 8

I sat this many hours in an average workday: 0 1 2 3 4 5 6 7 8

I climbed this much in an average workday:

☐ Never ☐ Occasionally ☐ Frequently ☐ Constantly

I bent over this much in an average workday:

☐ Never ☐ Occasionally ☐ Frequently ☐ Constantly

Heaviest weight I lifted: ☐ 10 lbs ☐ 20 lbs ☐ 50 lbs ☐ Over 100 lbs

I often lifted/carried up to: ☐ 10 lbs ☐ 20 lbs ☐ 50 lbs ☐ Over 100 lbs

Did you have any of your current medical problem(s) when you performed this job? ☐ Yes ☐ No

If NO, and you have had NO other jobs go to Part V, page 7, for your signature. If NO, but you have had other jobs, go to 17b, next page. If YES, please complete the following information.

Name of medical problem(s): _____

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

If YES, describe the special arrangements made: _____

Did you have to stop working because of your medical problem(s)? ☐ Yes ☐ No

If YES, when? Month _____ Day _____ Year _____

Have you done any other work for more than 30 days during the last 15 years? ☐ Yes ☐ No

If NO, go to Part V, page 7 for your signature. If YES, continue on 17b, next page.

17. b. Job title | Type of business

Dates worked (month/year) | Hours per week | Rate of pay | Per hour/wk/mo

From: _____ To: _____

DESCRIPTION OF THE JOB (This is what I did and how I did it)

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

I took this long to learn the job: _____ day(s) or _____ month(s).
I wrote, completed reports, or performed similar duties: ☐ Yes ☐ No
I had supervisory responsibilities ☐ Yes ☐ No

PHYSICAL ACTIVITY — **Circle One**

I walked this many hours in an average workday: 0 1 2 3 4 5 6 7 8
I stood this many hours in an average workday: 0 1 2 3 4 5 6 7 8
I sat this many hours in an average workday: 0 1 2 3 4 5 6 7 8

I climbed this much in an average workday:
☐ Never ☐ Occasionally ☐ Frequently ☐ Constantly

I bent over this much in an average workday:
☐ Never ☐ Occasionally ☐ Frequently ☐ Constantly

Heaviest weight I lifted: ☐ 10 lbs ☐ 20 lbs ☐ 50 lbs ☐ Over 100 lbs
I often lifted/carried up to: ☐ 10 lbs ☐ 20 lbs ☐ 50 lbs ☐ Over 100 lbs

Did you have any of your current medical problem(s) when you performed this job? ☐ Yes ☐ No

If NO, and you have had NO other jobs go to Part V, page 7, for your signature. If NO, but you have had other jobs, ask your county worker for additional pages. If YES, please complete the following information.

Name of medical problem(s): _____

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

If YES, describe the special arrangements made: _____

Did you have to stop working because of your medical problem(s)? ☐ Yes ☐ No

If YES, when? Month _____ Day _____ Year _____

Have you done any other work for more than 30 days during the last 15 years? ☐ Yes ☐ No

If NO, go to Part V, page 7 for your signature. If YES, ask your county worker for additional pages to complete.

PART V—SIGNATURE AND CERTIFICATION

I declare under penalty of perjury under the laws of the United States of America and the State of California that the information contained in this Supplemental Statement of Facts is true and correct.

Signature of Applicant	Date
➧	
Signature of Witness (If applicant signed with a mark)	Date
➧	
Signature of person helping applicant fill out the form	Date
➧	

You will need to sign an authorization for release of information for each clinic, hospital, and testing facility that you list and for each doctor you saw outside of a clinic or hospital. Your county worker will provide you with additional forms which you will need to sign.

Continued answer(s) to question(s) number 8 on page 2, number 9 on page 3, and number 10 on page 3. If you need more room, please ask your county worker for additional pages to complete.

COUNTY USE ONLY

List any additional **clinic** or **hospital** where you have been seen in the last 12 months:

Name of clinic/hospital

Patient/clinic or **member number** | Clinic/hospital telephone number ( )

Name of doctor(s) seen

ADDRESS of clinic/hospital (number, street, suite) City State ZIP code

Date first seen | Date last seen | Date of next appointment

Reason for the visit(s)

Did you stay in the **hospital** overnight? ☐ Yes ☐ No

If YES, date(s) entered: _____ date(s) left: _____

Were you seen in the **emergency** room? ☐ Yes ☐ No

If YES, date(s) seen: _____

List *ALL* medicines received: _____

List *ALL* treatments received and the dates the treatments were received: _____

MC 220 Signed ☐

List any additional doctor you saw **outside of the clinic(s) or hospital(s)** you have already listed:

Name of doctor(s)

Patient/clinic or **member number** | Doctor's telephone number ( )

Name of doctor(s) seen

ADDRESS of doctor (number, street, suite) City State ZIP code

Date first seen | Date last seen | Date of next appointment

Reason for the visit(s)

List *ALL* medicines received: _____

List *ALL* treatments received and the dates the treatments were received: _____

MC 220 Signed ☐

List any additional tests you have had in the last 12 months:

TEST PERFORMED	NAME AND ADDRESS OF OFFICE, CLINIC, OR HOSPITAL WHERE TEST(S) WAS COMPLETED.	DATE (MO/YR)
	Name Address (number, street, suite) City State ZIP code	
	Name Address (number, street, suite) City State ZIP code	

MC 220 Signed ☐

MC 220 Signed ☐

State of California - Health and Welfare Agency
Medi-Cal Program

Department of Health Services

MEDI-CAL
NOTICE OF ACTION
DENIAL OF BENEFITS DUE TO A FEDERAL SOCIAL SECURITY DISABILITY DETERMINATION

(County Stamp)

Case No.: _____

District: _____

Denial for: _____

_____
(Names)

Your application for Medi-Cal dated _____ has been denied.

You have been denied because of the following reasons:

Federal disability rules do not allow us to make a separate disability determination if any of the conditions below apply to you. The State must use the Social Security Administration's (SSA) disability determination under the conditions listed below.

The State has no authority to review your disability status if SSA denied your SSA and/or SSI disability claim through the SSA medical review process.

AND

You claim the same disabling condition considered by SSA.

OR

Your Medi-Cal application based on disability is within 12 months of the date that SSA and/or SSI determined that you were not disabled, and you now claim that your condition has gotten worse or changed.

Because your disabling condition has worsen, you MUST contact your local SSA office for your case to be reconsidered or reopened. (SEE SSA APPEAL RIGHTS ON ADDITIONAL PAGE.)

(If SSA REFUSES to reconsider or reopen your case, you may come back to the county and reapply for Medi-Cal.)

(You may also apply for Medi-Cal if SSI denied/discontinued your claim for reasons other than disability.)

This section is required by Title 42 of the Code of Federal Regulations, Part 435 and California Code of Regulations, Title 22, Sections 50005, 50006, 50167 and 50223.

IF YOU BELIEVE THAT THE DECISION TO DENY YOU THE RIGHT TO FILE A MEDI-CAL APPLICATION WAS INCORRECTLY MADE, PLEASE SEE THE BACK OF THIS NOTICE REGARDING YOUR RIGHTS TO APPEAL THIS ACTION WITH THE STATE

_____ (Eligibility Worker) _____ (Phone) _____ (Dated)

MC 239 SD (3/92)

YOUR HEARING RIGHTS

To Ask For a State Hearing

The right side of this sheet tells how.

- You only have 90 days to ask for a hearing.
- The 90 days started the day after we mailed this notice.
- You have a much shorter time to ask for a hearing if you want to keep your same benefits.

To Keep Your Same Benefits While You Wait For a Hearing

You must ask for a hearing before the action takes place.

- Your Cash Aid will stay the same until your hearing.
- Your Medi-Cal will stay the same until your hearing.
- Your Food Stamps will stay the same until the hearing or the end of your certification period, whichever is earlier.
- If the hearing decision says we are right, you will owe us for any extra cash aid or food stamps you got.

To Have Your Benefits Cut Now

If you want your Cash Aid or Food Stamps cut while you wait for a hearing, check one or both boxes.

☐ Cash Aid ☐ Food Stamps

To Get Help

You can ask about your hearing rights or free legal aid at the state information number.

Call toll free:	1-800-952-5253
If you are deaf and use TDD call:	1-800-952-8349

If you don't want to come to the hearing alone, you can bring a friend, an attorney or anyone else. You must get the other person yourself.

You may get free legal help at your local legal aid office or welfare rights group.

Other Information

Child Support: The District Attorney's office will help you collect child support even if you are not on cash aid. There is no cost for this help. If they now collect child support for you, they will keep doing so unless you tell them in writing to stop. They will send you any current support money collected. They will keep past due money collected that is owed to the county.

Family Planning: Your welfare office will give you information when you ask.

Hearing File: If you ask for a hearing, the State Hearing Office will set up a file. You have the right to see this file. The State may give your file to the Welfare Department, the U.S. Department of Health and Human Services and the U.S. Department of Agriculture. (W & I Code Section 10950)

NA BACK 6

HOW TO ASK FOR A STATE HEARING

The best way to ask for a hearing is to fill out this page and send or take it to:

You may also call 1-800-952-5253.

HEARING REQUEST

I want a hearing because of an action by the Welfare Department of _____ County about my

☐ Cash Aid ☐ Food Stamps ☐ Medi-Cal

☐ Other (list) _____

Here's why: _____

I will bring this person to the hearing to help me (name and address, if known):

_____

I need an interpreter at no cost to me. My language or dialect is: _____

My name: _____

Address: _____

Phone: _____

My signature: _____

Date: _____

State of California - Health and Welfare Agency
Medi-Cal Program

Department of Health Services

NOTIFICACION DE ACCION DE MEDI-CAL

NEGACION DE BENEFICIOS DEBIDO A UNA DETERMINACION FEDERAL DE INCAPACIDAD DE LA ADMINISTRACION DEL SEGURO SOCIAL

(Sello del Condado)

No. del Caso: _____

Distrito: _____

Negación para: _____

_____
(Nombres)

Su solicitud para Medi-Cal de fecha _____ha sido negada.

Se le ha negado debido a las siguientes razones:

Las normas federales sobre incapacidad no nos permiten hacer una determinación de incapacidad por separado si alguna de las condiciones siguientes, es pertinente a usted. El estado tiene que utilizar la determinación de la Administración del Seguro Social (SSA) sobre incapacidad bajo las condiciones enumeradas enseguida.

El estado no tiene la autoridad de hacer una revisión de la incapacidad suya si la SSA negó su reclamo para incapacidad de la SSA y/o el SSI, a través del proceso de revisión médico de la SSA.

Y

Usted alega la misma condición incapacitante que ya tomó en consideración la SSA.

O

Su solicitud para Medi-Cal con base en incapacidad cae dentro de los 12 meses contados a partir de la fecha en que la SSA y/o el SSI determinó que usted no estaba incapacitado, y ahora usted alega que su condición ha empeorado o ha cambiado.

Ya que su condición ha empeorado, usted TIENE QUE ponerse en contacto con su oficina local de la SSA para que vuelvan a considerar su caso, o para que lo vuelvan a abrir. (VEA LOS DERECHOS DE APELACION EN LA SSA EN LA PAGINA ADICIONAL.)

(Si la SSA SE REHUSA a volver a considerar o a abrir el caso suyo, puede regresar a la oficina del condado para volver a solicitar Medi-Cal.)

(También puede solicitar Medi-Cal si el SSI negó/descontinuó su reclamo por razones diferentes a la incapacidad.)

Esta sección la requiere el Título 42 del Código de Ordenamientos Federales, Parte 435, y Título 22, secciones 50005, 50006, 50167 y 50223 del Código de Ordenamientos de California.

SI USTED CREE QUE LA DECISON DE NEGARLE EL DERECHO A PRESENTAR UNA SOLICITUD PARA MEDI-CAL FUE INCORRECTA, POR FAVOR VEA EL REVERSO DE ESTA NOTIFICACION PARA ENTERARSE DE SU DERECHO A APELAR CON EL ESTADO ESTA ACCION

_____ (Trabajador de Elegibilidad) _____ (Teléfono) _____ (Fecha)

MC 239 SD (SP) (3/92)

SUS DERECHOS A UNA AUDIENCIA

Para pedir una audiencia con el estado.

El lado derecho de esta página le indica como hacerlo.

- Usted tiene solamente 90 días para solicitar una audiencia.
- Los 90 días comienzan [illegible] le enviamos esta notificación.
- Tiene menos tiempo para pedir una audiencia si desea seguir recibiendo los mismos beneficios.

Para conservar sus mismos beneficios mientras espera una audiencia

Debe solicitar una audiencia antes que la acción entre en vigor.

- Su asistencia monetaria permanecerá sin cambios hasta que se lleve a cabo su audiencia.
- Su Medi-Cal permanecerá sin cambios hasta que se lleve acabo su audiencia.
- Sus estampillas para comida permanecerán sin cambios hasta que se lleve a cabo la audiencia o hasta el fin de su período de certificación; lo que ocurra primero.
- Si la decisión de la audiencia indica que estamos en lo correcto, usted nos debera cualesquier dinero o estampillas para comida que haya recibido.

Para que se descontinúen ahora sus beneficios

Si usted desea que se descontinúen su asistencia monetaria o sus estampillas para comida mientras espera una audiencia, marque uno de los casilleros.

☐ Asistencia monetaria ☐ Estampillas para comida

Para que le asistan

Puede obtener información acerca de sus derechos a una audiencia o asesoría legal gratuita llamando al teléfono de información del estado.

Número gratuito	1-800-952-5253
Si es sordo y usa TDD:	1-800-952-8349

Si no desea venir a la audiencia solo, puede traer un amigo, un abogado o cualquier otra persona, pero usted debe hacer los arreglos para traer a esa otra persona.

Es posible que pueda obtener ayuda legal gratuita en su oficina local de asesoramiento legal (legal aid) o de su grupo de derechos de recipientes de asistencia pública.

Otra Información

Mantenimiento de hijos: La oficina del Fiscal del Distrito le ayudará a cobrar mantenimiento de hijos aun cuando no esté recibiendo asistencia monetaria. Esta asistencia es gratuita. Si en la actualidad están cobrando mantenimiento de hijos a su nombre, ellos continuarán haciéndolo hasta que usted les dé aviso por escrito indicándoles que paren. Le enviaran a usted cualesquier cantidades de mantenimiento que cobren. Se quedarán con las cantidades vencidas cobradas que se le deban al condado.

Planificación familiar: Su oficina de bienestar le proporcionará información cuando usted la solicite.

Expediente de la audiencia: Si usted solicita una audiencia, la oficina de audiencias con el estado formara un expediente. Usted tiene el derecho de examinar este expediente. El Estado puede dar su expediente al departamento de bienestar, al Departamento de Salud y Servicios Humanos de los Estacos Unidos y al Departamento de Agricultura de los Estados Unidos. (Seccion 10950 del Código de Bienestar e Instituciones)

HA BACK 6 - Spanish

COMO PEDIR UNA AUDIENCIA CON EL ESTADO

La mejor manera de solicitar una audiencia es llenar esta página y enviarla a:

Tambien puede llamar al 1-800-952-5253.

PETICION PARA UNA AUDIENCIA

Deseo solicitar una audiencia a causa de una acción ejercitada por el Departamento de Bienestar del Condado de _____ acerca de mi:

☐ Asistencia monetaria ☐ Estampillas para Comida

☐ Medi-Cal

☐ Otro (anote)_____

La razón es la siguiente: _____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

La siguiente persona vendrá conmigo a la audiencia a ayudarme (nombre y dirección si los sabe):

_____

_____

_____

Necesito un intérprete sin costo para mí.

Mi idioma es el: _____

Mi nombre: _____

Dirección: _____

_____

Teléfono: _____

Mi Firma: _____

Fecha: _____

IMPORTANT INFORMATION REGARDING YOUR APPEAL RIGHTS

SOCIAL SECURITY INFORMATION

Your Right To Appeal Through Social Security

If you disagree with the Social Security Administration (SSA) disability determination, you can ask that the determination be reviewed by either requesting a reconsideration or a reopening of your case. **If you want a reconsideration, you must ask for it within 60 days from the date you received the notice from Social Security that denied your application for SSI (Supplemental Security Income) or Disability Benefits.** If **more than 60 days have gone by from such date, you must give a good reason for the delay.** You may also file a new application at any time.

Your request must be made in writing through any SSA office. Be sure to tell them your name, Social Security number and why you disagree with the determination. Also tell them the date you were denied Medi-Cal by California. If you **have any questions as to how to file your request with Social Security, call your local SSA office immediately.** If you visit your Social Security office, please take this notice with you.

STATE OF CALIFORNIA INFORMATION

Regarding Your Medi-Cal Disability Status

The State has no authority to review your disability status if:

(1) you are claiming the same disabling condition which SSA considered and your condition has NOT gotten worse, NOT changed or you have NO new disabling condition;
(2) you are claiming the same disabling condition which SSA considered and your condition has changed or gotten worse; **AND**
(3) there was an SSA disability determination made within 12 months of the disability based Medi-Cal application, and SSA has NOT refused to reopen your case.

If you feel that the decision to deny you the right to file a disability based Medi-Cal application was incorrect, you should contact your local welfare office. Listed in (1) and (2) below are possible reasons which may allow you to apply for Medi-Cal based on disability.

(1) The disabling condition that you are reporting is new and different from the one considered by SSA.
(2) Your Medi-Cal application is within 12 months of the date of the SSA disability denial and your condition has changed or gotten worse and either:
   (a) SSA has refused to accept your request to reopen your case;
   OR
   (b) you no longer meet the income and resource requirements of SSI but you may meet the income and resource requirements of Medi-Cal.

State Hearing Right On Issues Other Than Your Disability

Though the State may not have the right or authority to give you a hearing on your disability status (**except see reasons under "If you feel that the decision..." above**), you do have a right to a state hearing regarding your eligibility for Medi-Cal if:

(1) there are minor children who live in the home who are deprived of parental care and support;
(2) you are under 21 years of age or 65 years of age or older;
(3) you are pregnant;
(4) you live in a nursing home, or;
(5) you are a refugee.

If you wish to file a state hearing, you may do so on the back of a Notice of Action.

MC INFORMATION NOTICE 13 (3/92)

INFORMACION IMPORTANTE ACERCA DE SUS DERECHOS DE APELACION INFORMACION CON RESPECTO AL SEGURO SOCIAL

Sus Derechos de Apelación por Medio del Seguro Social

Si usted no está de acuerdo con la determinación hecha por la Administración del Seguro Social (SSA) con respecto a la incapacidad, puede pedir que se vuelva a tomar en consideración su caso, o que se vuelva a abrir. **Si desea que se vuelva a tomar en consideración su caso, tiene que pedirlo en un plazo de 60 días contados a partir de la fecha en que usted reciba la notificación del Seguro Social indicando que han negado su solicitud para SSI (Seguridad de Ingreso Suplemental) o Beneficios de Incapacidad. Si pasan más de 60 días de tal fecha, deberá dar una razón justificada por su retraso.** También puede presentar una nueva solicitud en cualquier momento.

Tiene que presentar su petición por escrito a través de cualquier oficina de la SSA. Asegúrese de darles su nombre, su número del Seguro Social, y decirles por qué no está de acuerdo con la determinación. También dígales la fecha en que el Estado de California le negó el Medi-Cal. **Si tiene preguntas acerca de cómo presentar su petición al Seguro Social, llame de inmediato a su oficina de la SSA.** Si visita su oficina del Seguro Social, por favor lleve consigo esta notificación.

INFORMACION DEL ESTADO DE CALIFORNIA

Con Respecto a la Situación Suya Tocante al Medi-Cal Basado en Incapacidad

El Estado no tiene la autoridad para revisar la situación suya con respecto a incapacidad si:

(1) usted reclama la misma condición incapacitante que la SSA ha tomado en consideración, y su condición NO ha empeorado, NO ha cambiado, o usted NO tiene una condición nueva que le incapacite;

(2) usted está reclamando la misma condición incapacitante que ya tomó en consideración la SSA y su condición ha cambiado o ha empeorado; Y

(3) la SSA tomó una determinación en los últimos 12 meses contados a partir de la fecha en que se presentó la solicitud para Medi-Cal con base en incapacidad, y la SSA NO se ha rehusado a volver a abrir su caso.

Si usted cree que la decisión de negarle el derecho de presentar una solicitud para Medi-cal con base en incapacidad fue incorrecta, debería ponerse en contacto con su oficina local de bienestar. En seguida, en los números (1) y (2), se enumeran las posibles razones que pudieran permitir solicitar Medi-Cal con base en incapacidad.

(1) La condición incapacitante que usted está reportando es nueva y diferente de la que tomó en consideración la SSA.

(2) No han pasado 12 meses desde la fecha en que la SSA negó su solicitud para Medi-Cal, y su condición ha cambiado o empeorado, y ya sea que:

  (a) la SSA se ha rehusado a aceptar su petición para volver a abrir su caso; o

  (b) usted ya no reúne los requisitos de ingresos y recursos para recibir SSI, pero posiblemente reúna los requisitos de ingresos y recursos para recibir Medi-Cal.

Derecho a una Audiencia con el Estado con Respecto a Asuntos Diferentes a su Incapacidad

Aunque el Estado tal vez no tenga el derecho, o la autoridad de otorgarle una audiencia con relación a la situación de su incapacidad (**exceptuando las razones bajo "Si usted cree que la decisión..." de arriba**), usted tiene el derecho a una audiencia con el estado con respecto a su elegibilidad para recibir Medi-Cal si:

(1) hay hijos menores de edad que viven en el hogar, que están privados del cuidado y mantenimiento de sus padres;

(2) usted es menor de 21 años de edad o tiene 65 años de edad o más;

(3) usted está embarazada;

(4) usted vive en un establecimiento de cuidado continuo no intenso, o;

(5) usted es un(a) refugiado(a).

Si desea pedir una audiencia con el estado, puede hacerlo en el reverso de una Notificación de Acción.

MC INFORMATION NOTICE 13 (SP) (3/92)

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

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

1. PREPARING THE PACKET

A. LIMITED REFERRAL

Contains

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

Submit Only Under These Circumstances

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

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

   NOTE: If death certificate is not available, MC 220s signed by appropriate next-of-kin should be sent.

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

Caution Recommended in Limited Packet Referrals

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

B. FULL REFERRAL

A full referral packet contains the following forms:

MC 179

90-Day Status Letter

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

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

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

MC 220

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

MC 221

Disability Determination and Transmittal

MC 223

Applicant's Supplemental Statement of Facts for Medi-Cal

Appointment of Representative, If Applicable

Allows SP-DED to discuss case with Authorized Representative.

SSA Documents, If Applicable

If client had an SSA decision made prior to (or during) SP-DED's processing of a claim, it is imperative that a copy of the SSA document regarding benefits or the SSA denial letter and personalized denial notice be sent to SP-DED.

Death Certificate, If Applicable

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

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

C. PACKET INFORMATION FOR RETROACTIVE MEDI-CAL

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

D. REFERRALS FOR DISABLED FORMER SSI/SSP RECIPIENTS

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

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

Responsibilities

CWD

1. Submit a limited packet to SP-DED immediately upon client's application for Medi-Cal. Only the MC 221 is needed. Indicate in the Comments Section that "SSI/SSP discontinued for reasons other than cessation of disability".

2. Grant temporary Medi-Cal eligibility pending a formal disability determination by SP-DED.

SP-DED

1. SP-DED may be able to adopt SSA's disability decision and onset date by querying SSA records. The MC 221 will be sent to CWD indicating approval.

2. If SSA's mandatory reexam date (SSA expected the medical condition to improve) has passed or if SSA's disability decision cannot be verified, SP-DED may return a limited packet to CWD as a Z56 case (no determination). A full packet will be requested.

E. THE RAILROAD RETIREMENT BOARD (RRB) PACKET REFERRAL

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

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

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

1. Award Letter Available

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

Total And Permanent Disability

Client is disabled for Medi-Cal purposes. Retain copy of RRB's written statement; OR, document disability onset date (or date benefits began), type of RRB disability award, and date of verification for the file.

Occupational Disability

Occupational Disability is based on an inability to perform one's last railroad job and does not consider the ability to perform other work. Submit a full packet (MC 220, MC 221, MC 223) to SP-DED.

Type Of Award Not Identified

Client is responsible for obtaining a written statement from RRB which identifies the type of disability benefits awarded. Set a reasonable time frame for compliance. If the client is unable to obtain this verification, submit a full packet to SP-DED and an MC 220 which authorizes SP-DED to obtain copies of the RRB award information.

2. Award Letter Not Available

Occupational Disability

If client states that award is for Occupational Disability, and does not wish to obtain verification from RRB, refer full packet to SP-DED and include MC 220 which authorizes SP-DED to obtain copies of RRB award information.

Reclassification Request

If Medi-Cal beneficiary alleges that RRB has determined that he/she is disabled and would like to be reclassified to Medi-Cal disabled category but fails, or refuses without good cause, to cooperate in providing proof about RRB disability benefits, deny Medi-Cal request for reclassification on basis of failure to cooperate.

DO NOT DISCONTINUE MEDI-CAL BENEFITS until/unless all other linkage ceases or another reason for discontinuance exists.

2. SENDING THE PACKET

Check forms and information included in packet to ensure consistency of client's name, Social Security number and date of birth. Resolve any discrepancy pertaining to disability issues before sending packet.

Send packet to SP-DED no later than ten calendar days after date on the Statement of Facts (MC 223) is signed by client, unless there are circumstances beyond CWD's control. When the ten day rule is not met, the situation must be documented in case. However, do not hold packet pending CWD's evaluation/verification of other non-disability factors. If packet has already been sent and it is discovered that client is ineligible, send MC 222 to SP-DED.

Example: Client fails to give completed information to CWD timely. Case record documents this as the reason for not sending packet within ten days. CWD sends completed disability packet to SP-DED while continuing to verify property issues. While packet is at SP-DED, CWD discovers that client is ineligible. CWD sends MC 222 informing SP-DED that client is ineligible so that the disability evaluation can be stopped.

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

1. NOTIFYING SP-DED ABOUT CHANGES

A. MC 222 LA/ MC 222 OAK - DED PENDING INFORMATION UPDATE FORM

While a disability evaluation is pending, CWD will notify SP-DED about changes in client's situation which affect eligibility or which would enable SP-DED to contact client. MC 222 LA/OAK is used to submit changes and to report information to SP-DED.

CWDs who send packets to Los Angeles SP-DED will use MC 222 LA. Other CWDs who send packets to Oakland SP-DED will use MC 222 OAK.

B. TYPE OF CHANGES TO REPORT TO SP-DED

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

C. SP-DED ADDRESSES

Disability packets from ***Imperial, Los Angeles, Orange, Riverside, Kern and San Diego Counties*** must be sent to:	Department of Social Services Disability Evaluation Division **Los Angeles State Programs Branch** P.O. Box 30541, Terminal Annex Los Angeles, CA 90030 **(213) 965-3316 / 8-730-3316 CALNET** **FAX:** (800) 869-0188
Disability packets from ***all other Counties*** must be sent to:	Department of Social Services Disability Evaluation Division **Oakland State Programs Branch** P.O. Box 23645-0645 Oakland, CA 94623 **(510) 286-3706 / 8-541-3706 CALNET** **FAX:** (800) 869-0203

D. MC 4033 - DISABILITY LISTINGS UPDATE FORM

CWDs will use MC 4033 to notify the state of any changes to 1) Medi-Cal Liaison List for Disability Issues, or 2) Medi-Cal Liaison List for Quarterly Status Listings for Pending and Closed Disability cases. Check appropriate list and specify items being updated.

These lists are updated on a regular basis and contain names and phone numbers of CWD liaisons which DHS-MEB and SP-DED may need to communicate with CWDs.

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

A. QUARTERLY COMPUTER STATUS LIST

CWDs will receive a quarterly computer status list from SP-DED regarding pending and closed disability cases, along with instructions on its use. If a particular case was forwarded to SP-DED prior to most recent quarterly list and does not appear on list, CWD may contact SP-DED Operations Support Unit Supervisors by telephone or in writing to obtain status information, as follows:

Los Angeles State Programs Branch

Helen Cahueque
Operations Support Unit Supervisor
DSS - DED - LASPB
P.O. Box 30541, Terminal Annex
Los Angeles, CA 90030
(213) 965-3350 / 8-730-3350 CALNET

Oakland State Programs Branch

Lorraine Graff
Operations Support Unit Supervisor
DSS - DED - OSPB
P.O. Box 23645-0645
Oakland, CA 94623
(510) 286-0630 / 8-541-0630 CALNET

B. USE OF DISABILITY LISTINGS UPDATE FORM (MC 4033)

A combined list of Medi-Cal liaisons, district office codes, addresses and telephone numbers will be used to distribute the quarterly status reports. Form MC 4033 (Disability Listings Update) should be used and sent to the Department of Health Services (DHS) to provide updated information to the list. DHS' address is listed on the form.

C. QUESTIONS AND INQUIRIES ON SPECIFIC CASES

In urgent or unusual circumstances, questions and inquiries about specific cases may be directed to the Disability Evaluation Analyst (DEA) assigned to the case, or the Unit Manager. To determine which DEA or Unit is assigned to case, provide client's name and Social Security number to Masterfiles, at the following numbers:

Los Angeles State Programs Branch

Masterfiles:
(213) 965-3360 / 3361

8-730-3360 / 3361 CALNET

Oakland State Programs Branch

Masterfiles:
(510) 286-3706

8-541-3706 CALNET

If Good Cause Exists	After gaining client's cooperation, CWD must resubmit: 1. A limited packet containing a new MC 221 if there are no new allegations or treatment sources; <u>or</u> 2. A full packet containing a new MC 221 and MC 223 if a new medical condition is claimed and/or there are new or additional medical sources or information, <u>and</u> 3. Additional MC 220s, as necessary.
If Good Cause Does Not Exist	Deny application or discontinue beneficiary, if no other linkage exists.

2. <u>Determine Whether State Hearing Was Requested</u>

If State Hearing Requested by Client	CWD shall follow the decision of the hearing.
If State Hearing Not Requested by Client	CWD must have the client reapply.

Performs Medical Deferment

Cases can be medically deferred for up to three months when future evidence is needed to assess duration and severity of an impairment.

Medical deferment is an exception to the rule, rather than a routine procedure. Common reasons are strokes or heart surgery. SP-DED will send informational form SPB 101 to CWD which provides the reason for the medical deferment.

Documents Decision

When a decision is made, it is explained on MC 221 or its attachment. The original copy is sent to CWD.

NOTE: If a decision is less than fully favorable, CWD may use the Personalized Denial Notice to explain to client the reason for the decision, but should not send a copy of the MC 221 or its attachment with client's Notice of Action.

Performs Reexaminations

When a reexam date arrives, CWD must submit cases for a medical review by SP-DED, except for decisions which were adopted from a federal claim.

Disability ends if evidence shows there is medical improvement related to the ability to work, or the ability to engage in age-appropriate activities in Disabled Child cases.