STATE OF CALIFORNIA—HEALTH AND WELFARE AGENCY

GEORGE DEUKMEJIAN, Governor

DEPARTMENT OF HEALTH SERVICES
714 744 P STREET
SACRAMENTO, CA 95814

March 8, 1985

To: All County Welfare Directors
All County Administrative Officers

Letter No. 85- 19
Expiration Date: April 1, 1986

MEDI-CAL PRESUMPTIVE DISABILITY -- APPLICANTS WITH ACQUIRED IMMUNE DEFICIENCY SYNDROME (AIDS)

The purpose of this letter is to inform you that, effective immediately, counties shall establish presumptive disability for Medi-Cal applicants who have a confirmed diagnosis of AIDS. There is a high degree of probability that applicants with AIDS will be determined by the Disability Evaluation Division (DED) of the Department of Social Services to meet the disability criteria for the Medi-Cal program. Therefore, the Department of Health Services (DHS) has taken action to expand the presumptive disability standards set forth in Title 22, CAC, Section 50167(a)(1)(D) to include certain individuals with a confirmed diagnosis of AIDS. In order to be determined presumptively disabled, the applicant must provide the county with a medical statement from his/her physician which states the following:

The diagnosis of AIDS has been confirmed through laboratory testing and clinical findings demonstrating one of the following conditions:

1. Pneumocystis carinii Pneumonia or Kaposi's Sarcoma

2. Pneumonia, Meningitis, or Encephalitis due to one or more of the following:

   a. Aspergillosis

   b. Candidiasis

   c. Cryptococcosis

   d. Strongyloidosis

   e. Toxoplasmosis

   f. Zygomycosis

   g. Cytomegalovirus

   h. Nocardiasis

   i. Atypical Mycobacteriosis

3. Esophagitis due to one or more of the following:

   a. Candidiasis

   b. Cytomegalovirus

   c. Herpes simplex

4. Progressive Multifocal Leukoencephalopathy

5. Chronic Enterocolitis due to Cryptosporidiosis of more than four weeks duration.

6. Extensive Mucocutaneous Herpes Simplex of more than 5 weeks duration.

Where a diagnosis of AIDS is suspected, but is not confirmed by laboratory tests or clinical findings, disability cannot be presumed. In addition, if a diagnosis of AIDS is made, but none of the conditions shown above exist, the county cannot find the person to be presumptively disabled, however, the case should continue to be processed under regular disability evaluation procedures on an expedite basis.

In order to minimize the impact on eligibility workers and ensure all necessary information is obtained, we have prepared the attached form DHS 7035, Medical Verification -- AIDS, for completion by the treating physician. A blank DHS 7035 should be provided to the applicant, who is responsible for having the physician complete and sign the form. Please note that because the form requires certification under penalty of perjury, the statement must be signed by an M.D. Name stamps, signatures by a second party for the M.D. or signatures by other health professionals are not acceptable.

As with any case where the applicant is presumptively determined to be disabled, the case must be referred to DED for a complete disability determination as required by Title 22, CAC Section 50167(a)(1)(E). A copy of form DHS 7035 should be submitted to DED for any beneficiary granted presumptive disability due to AIDS.

A disability evaluation may be expedited in any case where immediate need for medical services is reported. To expedite a case, a note to DED should be made on the MC 221, Disability Determination and Transmittal, under "CWD Comments" stating that the applicant is in immediate need of emergency medical care and that the case should be expedited.

Further, if the applicant's medical records are readily available, the applicant may submit copies to be included with the disability evaluation package. In those cases where all the required documentation is submitted with the disability package, counties will usually receive a response from DED within seven to ten days. However, in no case should the county hold the disability referral pending receipt of such medical records. Title 22, CAC, Section

50167(a)(1)(E) requires the county to submit the request for disability evaluation to DED within ten days of the date the Statement of Facts is received. The responsibility for obtaining medical records lies with DED. DED has a system in place to assure that any such requests are controlled and, where necessary, the requests are pursued by DED staff. As an additional incentive to medical providers, DED pays for copies of the applicant's records or, in certain areas, contracts with private companies to obtain copies of the records.

Regulations are being prepared on a priority basis to expand the presumptive disability category. If you have any further questions or would like to provide comments on the proposed regulation change regarding AIDS or any other presumptive disability category, please call Toni Bailey at (916) 324-4953.

Sincerely,

Original signed by

Doris Z. Soderberg, Chief
Medi-Cal Eligibility Branch

cc: Medi-Cal Program Consultants
Medi-Cal Program Liaisons

MEDICAL VERIFICATION—AIDS

Patient's Name: _____ SSN: ____ – ____ – ____

I. I have examined the above named patient and diagnosed his/her condition as Acquired Immune Deficiency Syndrome (AIDS).

Yes ☐ No ☐

II. This diagnosis has been confirmed by clinical findings and reliable, currently accepted tests.

Yes ☐ No ☐

A. Skin Testing—Anergic:

Yes ☐ No ☐

B. T-Cell Ratio Abnormal:

Yes ☐ No ☐

III. In addition, the above named patient suffers from the following condition:

A. Pneumocystis Carinii Pneumonia ☐
B. Kaposi's Sarcoma ☐
C. Pneumonia ☐ Meningitis ☐ or Encephalitis ☐

This condition is due to:

1. Aspergillosis ☐
2. Candidiasis ☐
3. Cryptococcosis ☐
4. Strongyloidosis ☐
5. Toxoplasmosis ☐
6. Zygomycosis ☐
7. Cytomegalovirus ☐
8. Nocardiasis ☐
9. Atypical Mycobacteriosis ☐

D. Esophagitis

This condition is due to:

1. Candidiasis ☐
2. Cytomegalovirus ☐
3. Herpes Simplex ☐

E. Progressive Multifocal Leukoencephalopathy ☐

F. Chronic Enterocolitis due to Cryptosporidiosis ☐

G. Extensive Mucocutaneous Herpes Simplex of more than 5 weeks ☐

I certify under penalty of perjury that the above information is true and correct to the best of my knowledge.

_____ Physician's Signature

_____ Date