County Welfare Department Address

PLEASE PRINT

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

County number | Aid code | Case number

DDSD Address

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

1. Applicant name (first) (middle name) (last)

2. Social Security number
☐ Pending ☐ None

3. Date of birth
Month Day Year

4. Sex ☐ Male ☐ Female

5. Date applied
Month Day Year

6. List retro month(s)
___/___ ___/___ ___/___
Month/Year Month/Year Month/Year

7. Mailing address

Telephone number: (area code)

8. Type of referral (check appropriate box(es))

☐ Initial referral ☐ IHSS ☐ Retro-onset
☐ Redetermination ☐ SGA IHSS ☐ Limited referral
☐ Reevaluation ☐ SGA-disabled ☐ Other—explain (item 10)
☐ Pickle-blind ☐ CAPI
☐ Reexamination ☐ Resubmitted packet

9. Is applicant in a hospital? ☐ Yes ☐ No
Name of hospital:

10. County worker comment(s) (If more space is needed, attach a separate sheet.) ☐ See attached sheet (e.g., DHCS 7045)

☐ (MC 179) 90-Day Status Letter attached ☐ Presumptive Disability approved

11. File reviewed and approved for transmittal

Worker number | Print worker name

Telephone number (area code) | FAX number (area code) | 12. Date sent (Month Day Year)

DDSD USE ONLY

13. ☐ See attached DDSD Documents (This is NOT a certification for in-home supportive services.)

Comment(s) or SP-DDSD Presumptive Disability decision

14. Analyst | 15. Date

16. Team manager | 17. Date

DISABILITY DETERMINATION AND TRANSMITTAL

SEE BACK OF COPY 4 ☐ Oakland ☐ Los Angeles

Due to the fact that items 5, 6, and 8 are frequently misunderstood, the following explanations are given:

Item 5: Date applied: For a new Medi-Cal applicant, enter the date that the SAWS 1 was signed. For a continuing case, enter the date that the disability was first reported to the county.

Item 6: List retro month(s): List all months for which applicant requests coverage during the retroactive period (not more than three months prior to any application date).

Item 8: Check all boxes that apply.

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

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

Reevaluation: Check box if the county disagrees with DDSD's determination and is sending the case back for another review within 90 days of DDSD's decision. Reason for the disagreement must be explained in item 10. Attach a copy of the prior MC 221.

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

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

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

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

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

CAPI (Cash Assistance Program for Immigrants): This program provides cash assistance to aged, blind and disabled legal immigrants who meet the SSI immigration status requirements effective August 21, 1996, and all other current SSI eligibility requirements. If not aged (65 years of age or older), then disability/blindness must be established on an individual before CAPI payments can be made.

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

Retro-Onset: Check box only if the beneficiary was previously determined to be disabled and the case is being resubmitted to evaluate for an earlier onset date. (Onset cannot be granted more than three months prior to application.) Attach a copy of the prior MC 221 to the packet. **For new referrals, *DO NOT* check this box; simply indicate the requested onset in item 6.**

Limited Referral: Appropriate under the following circumstances: (1) A reevaluation packet is sent back within 30 days of DDSD decision and no new treating source alleged; (2) an earlier onset is needed after DDSD approved case (no new treating sources are alleged during earlier onset period) and it is within 12 months of application; (3) client discontinued from SSI due to excess income/resource and not receiving Title II disability benefits; (4) application is made on behalf of deceased client and death certificate is included; or (5) county unable to verify SSI benefits and only verification for SSI benefits for IHSS is requested.