MEDICAL SOURCE INSTRUCTION SHEET FOR COMPLETION OF ATTACHED DHS 7035 A

(Medical Report on Adult With Allegation of Human Immunodeficiency Virus [HIV] Infection)

Your patient, identified in Section A of the attached form, has filed a claim for Medi-Cal disability benefits based on HIV infection.
MEDICAL SOURCE: Please detach this instruction sheet and use it to complete the attached form.

I. PURPOSE OF THIS FORM:

If you complete and return the attached form promptly, your patient may be able to receive medical benefits while we are processing his or her claim for ongoing disability benefits.

This is not a request for an examination. At this time, we simply need you to fill out this form based on existing medical information. The State Disability Evaluation Division may contact you later to obtain further evidence needed to process your patient's claim.

II. WHO MAY COMPLETE THIS FORM:

A physician, nurse, or other member of a hospital or clinic staff, who is able to confirm the diagnosis and severity of the HIV disease manifestations based on your records, may complete and sign the form.

III. MEDICAL RELEASE:

A Department of Health Services medical release (MC 220) signed by your patient should be attached to the form when you receive it. If the release is not attached, the medical release section on the form itself should be signed by your patient.

IV. HOW TO COMPLETE THE FORM:

- If you receive the form from your patient and Section A has not been completed, please fill in the identifying information about your patient.
- You may not have to complete all of the sections on the form.
- **Always complete Section B.**
- **Complete Section C, if appropriate**. If you check at least one of the items in Section C, go right to Section E.
- **Only complete Section D if you have not checked any item in Section C.** See the special information section below which will help you to complete Section D.
- **Complete Section E if you wish to provide comments on your patient's condition(s).**
- **Always complete Sections F and G. Note: This form is not complete until it is signed.**

V. HOW TO RETURN THE FORM TO US:

- Mail the completed, signed form as soon as possible in the return envelope provided.
- If you received the form without a return envelope, give the completed, signed form back to your patient for return to the county department of social services.

VI. SPECIAL INFORMATION TO HELP YOU TO COMPLETE SECTION D:

How We Use Section D:

- Section D asks you to tell us what other manifestations of HIV your patient may have. It also asks you to give us an idea of how your patient's ability to function has been affected.
- We do not need detailed descriptions of the functional limitations imposed by the illness; we just need to know whether your patient's ability to function has been affected to a "marked" degree in any of the areas listed. See below for an explanation of the term "marked."

Special Terms Used in Section D:

What We Mean By "Repeated" Manifestations of HIV Infection *(see Item D.1)* :

"Repeated" means that a condition or combination of conditions:

- Occurs an average of three times a year, or once every four months, each lasting two weeks or more; or
- Does not last for two weeks, but occurs substantially more frequently than three times in a year or once every four months; or
- Occurs less often than an average of three times a year or once every four months but lasts substantially longer than two weeks.

What We Mean By "Manifestations of HIV Infection *(see Item D.1)* :

"Manifestations of HIV Infection" may include:

- Any conditions listed in Section C, but without the findings specified there, (e.g., carcinoma of the cervix not meeting the criteria shown in Item 22 of the form, diarrhea not meeting the criteria shown in Item 33 of the form); or any other condition that is not listed in Section C, (e.g., oral hairy leukoplakia, myositis).

- Manifestations of HIV must result in significant, documented symptoms and signs, (e.g., fatigue, fever, malaise, weight loss, pain, night sweats).

What We Mean By "Marked" Limitation or Restriction in Functioning *(see Item D.2):*

- When "marked" is used to describe functional limitations, it means more than moderate, but less than extreme. "Marked" does not imply that your patient is confined to bed, hospitalized, or in a nursing home.
- A marked limitation may be present when several activities or functions are impaired or even when only one is impaired. An individual need not be totally precluded from performing an activity to have a marked limitation, as long as the degree of limitation is such as to seriously interfere with the ability to function independently, appropriately, and effectively.

What We Mean By "Activities of Daily Living" *(see Item D.2):*

- Activities of daily living include, but are not limited to, such activities as doing household chores, grooming and hygiene, using a post office, taking public transportation, and paying bills.

  Example: An individual with HIV infection who, because of symptoms such as pain imposed by the illness or its treatment, is not able to maintain a household or take public transportation on a sustained basis or without assistance (even though he or she is able to perform some self-care activities) would have marked limitation of activities of daily living.

What We Mean By "Social Functioning" (see Item D.2):

- Social functioning includes the capacity to interact appropriately and communicate effectively with others.

  Example: An individual with HIV infection who, because of symptoms or a pattern of exacerbation and remission caused by the illness or its treatment, cannot engage in social interaction on a sustained basis (even though he or she is able to communicate with close friends or relatives) would have marked difficulty in maintaining social functioning.

What We Mean By "Completing Tasks in a Timely Manner" *(see Item D.2):*

- Completing tasks in a timely manner involves the ability to sustain concentration, persistence, or pace to permit timely completion of tasks commonly found in work settings.

  Example: An individual with HIV infection who, because of HIV-related fatigue or other symptoms, is unable to sustain concentration or pace adequate to complete simple work-related tasks (even though he or she is able to do routine activities of daily living) would have marked difficulty completing tasks.

PRIVACY ACT NOTICE

The California Department of Health Services (DHS) is authorized to collect the information on this form under Sections 205(a), 233(d), and 1633(e)(1) of the Social Security Act. The information on this form is needed by DHS to make a decision on the named applicant's application for Medi-Cal based on disability. While giving us the information on this form is voluntary, failure to provide all or part of the requested information could prevent an accurate or timely decision on the named applicant's application. Although the information you furnish is almost never used for any purpose other than making a determination about the applicant's disability, such information may be disclosed by DHS as follows: (1) to enable a third party or agency to assist DHS in establishing rights to Medi-Cal benefits, and (2) to facilitate statistical research and audit activities necessary to assure the integrity and improvement of the Medi-Cal program.

We may also use the information you give us when we match records by computer. Matching programs compare our records with those of other federal, state, and local government agencies. Many agencies may use matching programs to find or prove that a person qualifies for benefits paid by the Federal Government. The law allows us to do this even if you do not agree to it.

Federal law governing Medicaid requires that medical information on applicants and beneficiaries be kept confidential. [(42 United States Code, Section 139a (a) (7).)] The regulations implementing this law deal with the disclosure of information collected and maintained by state Medicaid agencies. (42 California Federal Register, Sections 431.300 et seq.)

MEDICAL REPORT ON ADULT WITH ALLEGATION OF HUMAN IMMUNODEFICIENCY VIRUS (HIV) INFECTION

The individual named below has filed an application for disability under the Medi-Cal program. If you complete this form, your patient may be able to receive early medical benefits. (This is not a request for an examination, but for existing medical information.)

MEDICAL RELEASE INFORMATION

☐ Form MC 220, "Authorization to Release Medical Information" to the Department of Health Services, attached.

☐ I hereby authorize the medical source named below to release or disclose to the Department of Health Services or Department of Social Services any medical records or other information regarding my treatment for human immunodeficiency virus (HIV) infection.

Applicant's signature (required only if Form MC 220 is NOT attached)	Date

A. IDENTIFYING INFORMATION:

Medical source's name	Applicant's name
Applicant's social security number	Applicant's date of birth

B. HOW WAS HIV INFECTION DIAGNOSED?

☐ Laboratory testing confirming HIV infection

☐ Other clinical and laboratory findings, medical history, and diagnosis(es) indicated in the medical evidence

C. OPPORTUNISTIC AND INDICATOR DISEASES (Please check, if applicable):

BACTERIAL INFECTIONS:

1. ☐ **Mycobacterial Infection,** (e.g. caused by M. avium-intracellulare, M. kansasii, or M. tuberculosis), at a site other than the lungs, skin, or cervical or hilar lymph nodes
2. ☐ **Pulmonary Tuberculosis,** resistant to treatment
3. ☐ **Nocardiosis**
4. ☐ **Salmonella Bacteremia,** recurrent nontyphoid
5. ☐ **Syphilis or Neurosyphilis,** (e.g., meningovascular syphilis) resulting in neurologic or other sequelae
6. ☐ **Multiple or Recurrent Bacterial Infection(s),** including pelvic inflammatory disease, requiring hospitalization or intravenous antibiotic treatment three or more times in one year

FUNGAL INFECTIONS:

7. ☐ **Aspergillosis**
8. ☐ **Candidiasis,** at a site other than the skin, urinary tract, intestinal tract, or oral or vulvovaginal mucous membranes; or candidiasis involving the esophagus, trachea, bronchi, or lungs.
9. ☐ **Coccidioidomycosis,** at a site other than the lungs or lymph nodes.
10. ☐ **Cryptococcosis**, at a site other than the lungs, (e.g., cryptococcal meningitis)
11. ☐ **Histoplasmosis**, at a site other than the lungs or lymph nodes
12. ☐ **Mucormycosis**

PROTOZOAN OR HELMINTHIC INFECTIONS:

13. ☐ **Cryptosporidiosis, Isosporiasis, or Microsporidiosis,** with diarrhea lasting for one month or longer
14. ☐ **Pneumocystis Carinii Pneumonia or Extrapulmonary Pneumocystis Carinii Infection**
15. ☐ **Strongyloidiasis,** extra-intestinal
16. ☐ **Toxoplasmosis,** of an organ other than the liver, spleen, or lymph nodes

VIRAL INFECTIONS:

17. ☐ **Cytomegalovirus Disease,** at a site other than the liver, spleen, or lymph nodes
18. ☐ **Herpes Simplex Virus,** causing mucocutaneous infection, (e.g., oral, genital, perianal) lasting for one month or longer; or infection at a site other than the skin or mucous membranes, (e.g., bronchitis, pneumonitis, esophagitis, or encephalitis); or disseminated infection
19. ☐ **Herpes Zoster,** disseminated or with multidermatomal eruptions that are resistant to treatment
20. ☐ **Progressive Multifocal Leukoencephalopathy**

SECTION C (continued)

21. ❒ **Hepatitis,** resulting in chronic liver disease manifested by appropriate findings, (e.g., persistent ascites, bleeding esophageal varices, hepatic encephalopathy)

MALIGNANT NEOPLASMS:

22. ❒ **Carcinoma of the Cervix,** invasive, FIGO stage II and beyond

23. ❒ **Kaposi's Sarcoma,** with extensive oral lesions; or involvement of the gastrointestinal tract, lungs, or other visceral organs; or involvement of the skin or mucous membranes with extensive fungating or ulcerating lesions not responding to treatment

24. ❒ **Lymphoma,** of any type, (e.g., primary lymphoma of the brain, Burkitt's lymphoma, immunoblastic sarcoma, other non-Hodgkin's lymphoma, Hodgkin's disease)

25. ❒ **Squamous Cell Carcinoma of the Anus**

SKIN OR MUCOUS MEMBRANES:

26. ❒ **Conditions of the Skin or Mucous Membranes,** with extensive fungating or ulcerating lesions not responding to treatment, (e.g., dermatological conditions such as eczema or psoriasis, vulvovaginal or other mucosal candida, condyloma caused by human papillomavirus, genital ulcerative disease)

HEMATOLOGIC ABNORMALITIES:

27. ❒ **Anemia** (hematocrit persisting at 30 percent or less), requiring one or more blood transfusions on an average of at least once every two months

28. ❒ **Granulocytopenia,** with absolute neutrophil counts repeatedly below 1,000 cells/mm^3 and documented recurrent systemic bacterial infections occurring at least three times in the last five months

29. ❒ **Thrombocytopenia,** with platelet counts repeatedly below 40,000/mm^3 with at least one spontaneous hemorrhage, requiring transfusion in the last five months; or with intracranial bleeding in the last 12 months.

NEUROLOGICAL ABNORMALITIES:

30. ❒ **HIV Encephalopathy,** characterized by cognitive or motor dysfunction that limits function and progresses

31. ❒ **Other Neurological Manifestations of HIV Infection,** (e.g., peripheral neuropathy), with significant and persistent disorganization of motor function in two extremities resulting in sustained disturbance of gross and dexterous movements, or gait and station

HIV WASTING SYNDROME:

32. ❒ **HIV Wasting Syndrome,** characterized by involuntary weight loss of ten percent or more of baseline (or other significant involuntary weight loss) and, in the absence of a concurrent illness that could explain the findings, involving: chronic diarrhea with two or more loose stools daily lasting for one month or longer; or chronic weakness and documented fever greater than 38°C (100.4°F) for the majority of one month or longer

DIARRHEA:

33. ❒ **Diarrhea,** lasting for one month or longer, resistant to treatment, and requiring intravenous hydration, intravenous alimentation, or tube feeding

CARDIOMYOPATHY:

34. ❒ **Cardiomyopathy** (chronic heart failure, or cor pulmonale, or other severe cardiac abnormality not responsive to treatment)

NEPHROPATHY:

35. ❒ **Nephropathy,** resulting in chronic renal failure

INFECTIONS RESISTANT TO TREATMENT OR REQUIRING HOSPITALIZATION OR INTRAVENOUS TREATMENT THREE OR MORE TIMES IN ONE YEAR:

36. ❒ **Sepsis**

37. ❒ **Meningitis**

38. ❒ **Pneumonia** (non-PCP)

39. ❒ **Septic Arthritis**

40. ❒ **Endocarditis**

41. ❒ **Sinusitis,** radiographically documented

NOTE: If you **have** checked any of the boxes in **Section C**, proceed to **Section E** to add any remarks you wish to make about this patient's condition. then proceed to **Sections F and G** and sign and date the form.

If you have **not** checked any of the boxes in **Section C**, please complete **Section D**. See Part VI of the Instruction Sheet for definitions of the terms we use in **Section D**. Proceed to **Section E** if you have any remarks you wish to make about this patient's condition. Then, proceed to **Sections F and G** and sign and date the form.

D. OTHER MANIFESTATIONS OF HIV INFECTION:

1. **Repeated Manifestions of HIV Infection,** including diseases mentioned in Section C, Items 1–41, but without the specified findings described above, or other diseases, resulting in significant, documented symptoms or signs, (e.g., fatigue, fever, malaise, weight loss, pain, night sweats). **Please specify:**

   a. The manifestations your patient has had;
   b. The number of episodes occurring in the same one-year period; and
   c. The approximate duration of each episode.

   Remember, your patient need not have the same manifestation each time to meet the definition of repeated manifestations; but, all manifestations used to meet the requirement must have occurred in the same one-year period. (See attached instructions for the definition of "repeated manifestations.")

   If you need more space, please use Section E:

MANIFESTATIONS	NUMBER OF EPISODES IN THE SAME ONE-YEAR PERIOD	DURATION OF EACH EPISODE
EXAMPLE: Diarrhea	**3**	**1 month each**

AND

2. **Any of the Following:**

   ❒ Marked restriction of **Activities of Daily Living;** or

   ❒ Marked difficulties in maintaining **Social Functioning;** or

   ❒ Marked difficulties in completing tasks in a timely manner due to deficiencies in **Concentration, Persistence, or Pace.**

E. REMARKS (Please use this space if you lack sufficient room in Section D or to provide any other comments you wish about your patient.):

F. MEDICAL SOURCE INFORMATION (Please Print or Type):

Name

Street Address	City	State	ZIP Code

Telephone Number (Include Area Code)	Date
( )	

I declare under penalty of perjury under the laws of the United States of America, that the information contained in this medical report is true and correct.

G. SIGNATURE AND TITLE OF PERSON COMPLETING THIS FORM (e.g., physician, R.N.):

FOR OFFICIAL USE ONLY

❒ COUNTY OFFICE DISPOSITION: ____________________

❒ DISABILITY EVALUATION DIVISION DISPOSITION: ____________________