

County Welfare Department Address

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

County No.	Aid Code	Case Number
-	-	-

DED ADDRESS

1. Applicant Name (Last, First, Mi)

2. Soc. Sec. No.	3. Date of Birth	4. Sex
- -	- -	<input type="checkbox"/> M <input type="checkbox"/> F

7. Mailing Address

Telephone No.: ()

*5. Date Applied

*6. List Retro Month(s)

Mo	Yr	Mo	Yr	Mo	Yr
----	----	----	----	----	----

*8. Type of Referral (check appropriate box(es))

<input type="checkbox"/> Initial Referral	<input type="checkbox"/> Retro-Onset	<input type="checkbox"/> Reevaluation
<input type="checkbox"/> Reexamination	<input type="checkbox"/> Redetermination	<input type="checkbox"/> Resubmitted Packet
<input type="checkbox"/> SGA-Disabled	<input type="checkbox"/> OBRA	<input type="checkbox"/> IRCA
<input type="checkbox"/> Pickle-Blind	<input type="checkbox"/> IHSS	<input type="checkbox"/> SGA IHSS

9. Is applicant in a hospital?

Yes No

Name of Hospital:

10. County Worker Comment(s) (If More Space Needed, Attach Separate Sheet) See Attached Sheet

90 Day Status Letter Attached Presumptive Disability Approved

11. File Reviewed and Approved for Transmittal

Worker No. _____ Worker Name _____ (print name) Telephone _____

12. Date Sent _____

DED USE ONLY

13. It is determined that the applicant

Is Disabled Is Blind Continues to be Disabled

Disability/Blindness Onset Date 9/95

Reexam Date 1/99

Was Disabled from _____ to _____

Is Not Disabled Is Not Blind Ceases to be Disabled

14. No Determination

Cooperation Issue Withdrawal of Application

Whereabouts Unknown

No Response Other

Reg-Basis Code A61

15. Diagnosis

1. Alcoholism

2. Pancreatitis

16. Basis For Decision (This is NOT a Certification for IHSS) See Attached Sheet

Listing 12.09

17. Analyst A. Rite 18. Date 1/8/96 19. Physician [Signature] 20. Date 1/8/96

DISABILITY DETERMINATION AND TRANSMITTAL

OAKLAND LOS ANGELES

County Welfare Department Address

ENCLOSURE 2

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

County No. Aid Code Case Number

DED ADDRESS

1. Applicant Name (Last, First, Mii)

2. Soc. Sec. No.

3. Date of Birth

4. Sex

M
 F

7. Mailing Address

*5. Date Applied

*6. List Retro Month(s)

Mo Yr Mo Yr Mo Yr

Telephone No.: ()

*8. Type of Referral (check appropriate box(es))

- Initial Referral
- Reexamination
- SGA-Disabled
- Pickle-Blind
- Retro-Onset
- Redetermination
- OBRA
- IHSS
- Reevaluation
- Resubmitted Packet
- IRCA
- SGA IHSS

9. Is applicant in a hospital?

Yes No

Name of Hospital:

10. County Worker Comment(s) (If More Space Needed, Attach Separate Sheet) See Attached Sheet

90 Day Status Letter Attached

Presumptive Disability Approved

11. File Reviewed and Approved for Transmittal

Telephone

12. Date Sent

Worker No. _____ Worker Name _____
(print name)

() _____

DED USE ONLY

13. It is determined that the applicant

- Is Disabled Is Blind Continues to be Disabled
- Disability/Blindness Onset Date 1/96
- Reexam Date 6/97
- Was Disabled from _____ to _____
- Is Not Disabled Is Not Blind Ceases to be Disabled

14. No Determination

- Cooperation Issue Withdrawal of Application
- Whereabouts Unknown
- No Response Other

Reg-Basis Code

A62

15. Diagnosis

1. Drug Addiction
2. Personality Disorder

16. Basis For Decision (This is NOT a Certification for IHSS) See Attached Sheet

Listing

17. Analyst

M. McCloud

18. Date

6/29/96

19. Physician

[Signature]

20. Date

6/3/96

DISABILITY DETERMINATION AND TRANSMITTAL

OAKLAND

LOS ANGELES

County Welfare Department Address

ENCLOSURE 3

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

County No.	Aid Code	Case Number
-	-	-

DED ADDRESS

1. Applicant Name (Last, First, Mii)

2. Soc. Sec. No.	3. Date of Birth	4. Sex
- -	- -	<input type="checkbox"/> M <input type="checkbox"/> F

7. Mailing Address

Telephone No.: ()

*5. Date Applied

*6. List Retro Month(s)

Mo	Yr	Mo	Yr	Mo	Yr
----	----	----	----	----	----

*8. Type of Referral (check appropriate box(es))

<input type="checkbox"/> Initial Referral	<input type="checkbox"/> Retro-Onset	<input type="checkbox"/> Reevaluation
<input type="checkbox"/> Reexamination	<input type="checkbox"/> Redetermination	<input type="checkbox"/> Resubmitted Packet
<input type="checkbox"/> SGA-Disabled	<input type="checkbox"/> OBRA	<input type="checkbox"/> IRCA
<input type="checkbox"/> Pickle-Blind	<input type="checkbox"/> IHSS	<input type="checkbox"/> SGA IHSS

9. Is applicant in a hospital?

Yes No

Name of Hospital:

10. County Worker Comment(s) (If More Space Needed, Attach Separate Sheet) See Attached Sheet

90 Day Status Letter Attached Presumptive Disability Approved

11. File Reviewed and Approved for Transmittal

Worker No. _____ Worker Name _____ (print name) _____ Telephone _____

12. Date Sent _____

DED USE ONLY

13. It is determined that the applicant

Is Disabled Is Blind Continues to be Disabled

Disability/Blindness Onset Date 12/95

Reexam Date 7/97

Was Disabled from _____ to _____

Is Not Disabled Is Not Blind Ceases to be Disabled

14. No Determination

Cooperation Issue Withdrawal of Application

Whereabouts Unknown Other

No Response

Reg-Basis Code A63

15. Diagnosis

Substance Abuse

Low back pain

16. Basis For Decision (This is NOT a Certification for IHSS) See Attached Sheet

Listing _____

17. Analyst J. Smith 18. Date 7/8/96 19. Physician John Doe, MD 20. Date 7/8/96

DISABILITY DETERMINATION AND TRANSMITTAL

OAKLAND LOS ANGELES

* SEE BACK OF COPY 4
MC 221 (6/93)

**MEDI-CAL
NOTICE OF ACTION
CHANGE IN SHARE OF COST**

ENCLOSURE 4

(COUNTY STAMP)

CASE NAME: _____

CASE NO.: _____

DISTRICT: _____

CHANGE IN SHARE OF COST FOR: _____

(SUGGESTED SAMPLE LANGUAGE BELOW IN ITALICS)

Your share of cost has been changed to \$ _____ per month beginning _____ because: _____ (names)

Your new share of cost was determined as follows:

Monthly Gross Income	\$ _____
Monthly Net Nonexempt Income	\$ _____
Maintenance Need	\$ _____
Excess Income/Share of Cost	\$ _____

The regulations which require this action are California Code of Regulations, Title 22, Section(s): *(Reference the usual sections pertaining to share of cost changes and ADD sections 50223 and Section 223(d)(2) of the Social Security Act.)*

TAKE YOUR PLASTIC CARD TO YOUR MEDICAL PROVIDER WHENEVER YOU NEED CARE. DO NOT THROW AWAY YOUR PLASTIC CARD.

If you have questions about this action or if there are more facts about your conditions which you have not reported to us, please write or telephone. We will answer your questions or make an appointment to see you.

You are not disabled according to new federal law which says that a person cannot get Medi-Cal benefits based on disability where drug addiction and/or alcoholism was the main reason for the disability. Your Medi-Cal will not stop because you are still able to get it for another reason. But your household will not be eligible for any type of special income deductions which are given to the disabled. This is why your share of cost has changed.

If you disagree with the decision that your disability is based mainly on drug addiction and/or alcoholism or if you have other physical or mental problems, be sure to let us know right away.

(Eligibility Worker)_____
(Phone)_____
(Date)

MC 239 C-M (Suggested sample language)

MEDI-CAL NOTICE OF ACTION DISCONTINUANCE OF BENEFITS

ENCLOSURE 5

(COUNTY STAMP)

Notice Date: _____

Case No.: _____

Worker Name/No.: _____

Worker Telephone No.: _____

Discontinuance for: _____
(Name)

Your eligibility to receive Medi-Cal will be discontinued effective the last day of _____
(Month/Year)

A new federal law says that any person receiving Medi-Cal benefits based on disability where drug addiction and/or alcoholism (DA&A) was the main reason for the finding of disability must be discontinued. This means that you would not be disabled if you stopped using drugs and/or alcohol.

We cannot continue your Medi-Cal benefits because you are not disabled according to the new law and because you also do not meet any of the other basic rules for Medi-Cal which are the following:

- Over 65 years old or blind
- Under 21 years old
Pregnant
- The parent/caretaker relative of a child whose parent(s) is/are absent from the home, deceased, incapacitated, or unemployed (not working or working less than 100 hours per month and who meet federal unemployment requirements)
- Eligible for the refugee program
- Recipient of Aid to Families With Dependent Children or Supplemental Security Income/State Supplementary Payment (SSI/SSP)

YOU SHOULD APPEAL IF YOU BELIEVE THE FOLLOWING:

You disagree with the decision that your disability is based mainly on drug addiction and/or alcoholism and you want to have a new disability decision made.

You feel you meet any of the other rules for Medi-Cal stated above.

If you have any questions about this action or if there is additional information about your situation which you have not reported to us, please write or call to make an appointment to see us right away.

The regulations which require this action are California Code of Regulations, Title 22, Sections 50005, 50006, 50167, 50201, 50205, 50209, 50211, 50213, 50215, 50219, 50221, 50223, 50251, and Section 223(d)(2) of the Social Security Act.

PLEASE READ THE REVERSE SIDE OF THIS NOTICE ON HOW TO APPEAL

Notice Date: _____

Case Number: _____

Worker Name/Number: _____

Worker Telephone Number: _____

Denial For: _____
(Name)

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

The law says that a person cannot be found eligible for Medi-Cal benefits based on disability if the main reason for his/her disability is due to drug addiction and/or alcoholism (DA&A). This means that a person would not be disabled if he/she stopped using drugs and/or alcohol.

Because it was found that

- 1) Drug addiction and/or alcoholism is the main condition(s) contributing to your disability; AND
- 2) You have no other severe physical and/or mental condition(s) to find you disabled, we cannot grant you Medi-Cal eligibility.

You also do not meet any of the other basic rules for Medi-Cal which are the following:

- Over 65 years old or blind
- Under 21 years old
- Pregnant
- The parent/caretaker relative of a child whose parent(s) is/are absent from the home, deceased, incapacitated or unemployed (not working or working less than 100 hours per month and who meet federal unemployment requirements)
- Eligible for the refugee program
- Recipient of Aid to Families With Dependent Children or Supplemental Security Income/State Supplementary Payment

If you do not agree with this decision and you have other physical and/or mental condition(s) that could find you disabled, you have a right to appeal. You also have a right to appeal if you feel you meet any of the other rules for Medi-Cal stated above. The back of this notice tells you how.

If you have any questions about this action or if there is additional information about your situation which you have not reported to us, please write, or call to make an appointment to see us right away.

The regulation which requires this action is California Code of Regulations, Title 22, Sections 50005, 50006, 50167, 50201, 50205, 50209, 50211, 50213, 50215, 50219, 50221, 50223, 50251.

PLEASE READ THE REVERSE SIDE OF THIS NOTICE

NOTIFICACIÓN DE ACCIÓN SUSPENSIÓN DE BENEFICIOS

ENCLOSURE 6

(COUNTY STAMP)

Fecha de Notificación: _____

Nº de Caso: _____

Nº/Nombre del Trabajador: _____

Teléfono del trabajador: _____

La suspensión es para: _____
(Nombre)Su derecho a recibir beneficios de Medi-Cal será suspendido a partir del último día de _____
(Mes/Año)

Una nueva ley federal establece que se debe suspender el derecho a recibir beneficios de Medi-Cal por incapacidad a aquellas personas a las que se determinó incapacitadas principalmente por su adicción a las drogas y/o el alcoholismo (DA&A). Esto significa que usted no estaría incapacitado si dejara de usar drogas y/o alcohol.

No podemos continuar otorgándole beneficios de Medi-Cal debido a que, de acuerdo con la nueva ley, usted no está incapacitado. Además, usted tampoco cumple con ninguno de los requisitos básicos de Medi-Cal que se enumeran a continuación:

- Mayor de 65 años o ciego
- Menor de 21 años
- Embarazada
- El padre/madre/pariente a cargo del cuidado continuo de un niño cuyo padre, madre o ambos están ausentes de la casa, han fallecido, están incapacitados o desempleados (sin trabajo o que trabajan menos de 100 horas al mes y que reúnen los requisitos federales para desempleo)
- Elegible para el programa de refugiados
- Beneficiario de Asistencia para Familias con Niños Necesitados o Ingreso de Seguro Suplementario/Programa Suplementario del Estado (SSI/SSP)

USTED DEBERÍA APELAR SI USTED ESTÁ CONVENCIDO DE UNO DE LOS SIGUIENTES:

Usted está en desacuerdo con la determinación de que su incapacidad se debe principalmente a la adicción a las drogas y/o el alcoholismo y desea que se revise su caso a fin de llegar a una nueva determinación.

Usted considera que cumple con alguno de los requisitos de Medi-Cal arriba mencionados.

Si tiene alguna pregunta sobre esta acción o si existe información adicional sobre su situación que no nos haya facilitado, por favor escríbanos o comuníquese con nosotros para hacer una cita cuanto antes.

La regulación que requiere esta acción es el Código de Ordenamientos de California, Título 22, secciones 50005, 50006, 50167, 50201, 50205, 50209, 50211, 50213, 50215, 50219, 50221, 50223, 50251 y la sección 223(d)(2) del Acta del Seguro Social.

LEA AL REVERSO DE ESTA NOTIFICACIÓN CÓMO INICIAR EL PROCESO DE APELACIÓN

State of California - Health and Welfare Agency
Department of Health Services
Medical Assistance

Notice Type 22
Notice Preparation Date:
MO/YR

MEDI-CAL DISCONTINUANCE OF SSI/SSP MEDI-CAL
NOTICE OF ACTION NO LONGER DISABLED

NAME

Social Security Number:

ADDRESS

Beneficiary ID Number:

The Social Security Administration (SSA) has told us that you are no longer eligible to receive a Supplemental Security Income/State Supplementary Payment (SSI/SSP) program check. This is because SSA has found that you are no longer disabled. Because you are not receiving an SSI/SSP check, your SSI-based Medi-Cal will stop as of _____. (INSERT DATE OF SSI DISCONTINUANCE)

You may also be one of those recipients who is affected by the new federal law which says that a person must be discontinued from SSI/SSP and/or Medi-Cal if these benefits were based on a disability where drug addiction and/or alcoholism was the main reason for the disability. This means that if SSA had not considered your drug addiction and/or alcoholism, you would not have been found disabled.

The regulations which require this action are California Administrative Code, Title 22, Sections 50183, 50227, 50703, and Section 223(d)(2) of the Social Security Act.

IF YOUR SSI/SSP HAS STOPPED, THIS IS IMPORTANT TO YOU

Even though you are no longer eligible for an SSI/SSP Medi-Cal card, you may still be eligible for Medi-Cal benefits under another Medi-Cal category or another disability which was not looked at by SSA.

DO NOT THROW AWAY YOUR PLASTIC MEDI-CAL ID CARD. You can use it again if you become eligible for Medi-Cal.

DO YOU STILL WANT MEDI-CAL?

If you do, then follow these instructions:

- Complete the enclosed Medi-Cal forms
- Mail the forms IMMEDIATELY to your nearest County Welfare Department or to the following address:

(INSERT STANDARD RAMOS COUNTY CONTACT)

DO YOU NEED HELP WITH THE FORMS?

If you have questions on how to fill out the forms or if you have questions about Medi-Cal, contact your nearest County Welfare Department or the county at the address or phone number given above.

The county will contact you to set up an appointment for you to come in for an interview with a county worker. You **MUST** complete the forms and go to the interview before they can decide whether you can get Medi-Cal. If you do not return the forms and do not go to the interview, your Medi-Cal eligibility will end the month shown above.

KEEP THIS LETTER TO SHOW TO THE COUNTY WELFARE DEPARTMENT

WOULD YOU LIKE MORE INFORMATION?

If you need more information about the changes in this notice, you may call the following:

- Toll-Free Number: 1-800-248-8068
- For the hearing impaired (TDD) only: 1-800-952-8349

PLEASE IGNORE THIS NOTICE IF

You have contacted SSA and have been told that you will once again receive an SSI/SSP check. SSA will tell the Department of Health Services to put you back on Medi-Cal which will take about 4 to 6 weeks. If you have a medical emergency and need Medi-Cal before the system can put you back on, contact your local SSA office and they will give you a form which you will need to take to your nearest County Welfare Department.

HAS THE STATE BEEN PAYING YOUR MEDICARE PART B PREMIUMS?

Even though you are no longer eligible for an SSI/SSP Medi-Cal card, you may still be eligible for Medi-Cal benefits under another Medi-Cal category. If the State has been paying your Medicare Part B premiums, you may again be eligible for this benefit. There may, however, be a break in coverage during which Part B premiums may be either taken out of your Title II Social Security check, or you may receive a bill for your Part B premiums. To reduce the break in coverage, we recommend that you contact your county welfare office as soon as possible to apply for Medi-Cal. If you received a Part B premium bill, you should take this bill to the welfare office when you apply. If premiums have been taken out of your check, you should tell the county welfare office when you apply. The county welfare office will tell you about how you can get a refund or get the bill paid for by Medi-Cal.

IF YOU WANT A FAIR HEARING
SEE ENCLOSED "YOUR RIGHT TO APPEAL THIS ACTION"

YOUR RIGHT TO APPEAL THIS ACTION ENCLOSURE 8

If you are dissatisfied with the action described on the attached notice, you may request a state hearing before an Administrative Law Judge of the California Department of Social Services. This hearing will be conducted in an informal manner to assure that everyone present is able to speak freely. If you decide to request a hearing, you must do so **WITHIN 90 DAYS OF THE MAILING DATE OF THE NOTICE.**

This hearing will determine if you were properly discontinued from SSI/SSP-based Medi-Cal. This hearing will not determine whether your eligibility for SSI/SSP was correctly discontinued. In order to determine your eligibility for Medi-Cal under another program, you must apply at the county welfare department.

A state hearing and aid paid pending described below will not be available if the only action you object to is an automatic change in your eligibility which is required by state or federal law. This denial of a state hearing is required by Title 22, CCR, Section 50951.

Aid Paid Pending

If you are now receiving Medi-Cal and ask for a state hearing **BEFORE THE EFFECTIVE DATE OF THE ACTION**, your Medi-Cal will continue with no change until the hearing.

State Regulations Available

State regulations, including those covering state hearings, are available at your local county welfare office.

Authorized Representative

You can represent yourself at the state hearing. You can also be represented by a friend, attorney, or any other person whom you designate below. You are expected to arrange for the representative yourself. You can get help in locating free legal assistance by calling the toll-free number of the Public Inquiry and Response Unit, 1-(800)-952-5253.

Information Practices Act Notice (California Civil Code, Section 1798, et. seq.)

The information you are asked to write in below is needed to process your hearing request. Processing may be delayed if the information is incomplete. A case file will be set up by the Chief Administrative Law Judge. You have the right to examine the materials that make up the record for decision and may locate this record by contacting the Public Inquiry and Response Unit (phone number shown below). Any information you provide may be shared with the county welfare department and with the U.S. Department of Health and Human Services (Authority: Welfare and Institutions Code, Section 14100.2).

How to Request a State Hearing

The best way to request a hearing is to fill in and send this entire notice to:

Administrative Adjudications Division
California Department of Social Services
P.O. Box 944243, Mail Station 19-97
Sacramento, CA 94244-2430

You may also request a hearing by calling the toll-free number of the Public Inquiry and Response Unit.

Public Inquiry and Response Unit (Public Information)

Toll-Free Number: 1-800-952-5253
For the deaf (TDD) only: 1-800-952-8349

The State Public Inquiry and Response Unit can provide you with further information about your hearing rights. Assistance is also available in some languages other than English, including Spanish. You may write to:

Public Inquiry and Response Unit
California Department of Social Services
P.O. Box 944243, Mail Station 16-23
Sacramento, CA 94244-2430

REQUEST FOR A STATE HEARING (RAMOS)

Name (print)	Social Security number	Phone number	
Address (number, street)	City	State	ZIP code

I am requesting a state hearing because of an action taken by the State of California related to Medi-Cal. **I UNDERSTAND THAT FOR A DETERMINATION OF MY ELIGIBILITY FOR MEDI-CAL UNDER ANOTHER PROGRAM, I MUST APPLY TO THE COUNTY WELFARE DEPARTMENT.**

Reason(s) for my request: _____

Do you speak a language other than English and need an interpreter. (The State will provide the interpreter at no cost to you.)

Language	Dialect
----------	---------

Do you authorize the following person and/or organization to act on my behalf for purposes of this appeal:

Name	Phone number		
Address (number, street)	City	State	ZIP code
Signature	Date		

MEDI-CAL NOTICE OF ACTION DENIAL OF BENEFITS

ENCLOSURE 9

Notice Date: _____

Case Number: _____

Worker Name/Number: _____

Worker Telephone Number: _____

Denial For: _____
(Name)

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

The law says that a person cannot be found eligible for Medi-Cal benefits based on disability if the main reason for his/her disability is due to drug addiction and/or alcoholism (DA&A). This means that a person would not be disabled if he/she stopped using drugs and/or alcohol.

Because it was found that

- 1) Drug addiction and/or alcoholism is the main condition(s) contributing to your disability; AND
- 2) You have no other severe physical and/or mental condition(s) to find you disabled, we cannot grant you Medi-Cal eligibility.

You also do not meet any of the other basic rules for Medi-Cal which are the following:

- Over 65 years old or blind
- Under 21 years old
- Pregnant
- The parent/caretaker relative of a child whose parent(s) is/are absent from the home, deceased, incapacitated or unemployed (not working or working less than 100 hours per month and who meet federal unemployment requirements)
- Eligible for the refugee program
- Recipient of Aid to Families With Dependent Children or Supplemental Security Income/State Supplementary Payment

If you do not agree with this decision and you have other physical and/or mental condition(s) that could find you disabled, you have a right to appeal. You also have a right to appeal if you feel you meet any of the other rules for Medi-Cal stated above. The back of this notice tells you how.

If you have any questions about this action or if there is additional information about your situation which you have not reported to us, please write, or call to make an appointment to see us right away.

The regulation which requires this action is California Code of Regulations, Title 22, Sections 50005, 50006, 50167, 50201, 50205, 50209, 50211, 50213, 50215, 50219, 50221, 50223, 50251.

PLEASE READ THE REVERSE SIDE OF THIS NOTICE

PROCESSING DRUG & ALCOHOL ADDICTION (DA&A) CASES
MNO - DISABLED*

1. Identifying DA&A Cases:

Find the most recent MC 221. DA&A cases are coded as follows:

Item 13: "Is Disabled" or "Continues to be disabled";

Item 14: Reg Basis Code of A61, A62, A63, or A65;

Item 15: Shows diagnosis of: Alcoholism, Alcoholic Liver Disease, Substance Abuse or Addiction, or Drug Abuse or Addiction. May also include a diagnosis of pancreatitis, personality disorder, low back pain, etc.; and

Item 16: If Item 14 is A61, then "12.09" is usually present. If Item 14 is A62, then "12.09" may be present. Otherwise, this item is blank.

2. **Determine if eligible on some basis other than disability.** If eligible, change aid code, income deductions, and SOC as necessary. Send NOA, if there is a SOC change. If no other basis for eligibility, go to next step.
3. **Send timely discontinuance NOA (MC 314).** *Do not discontinue prior to 12/31/96.* Provide aid paid pending the hearing, if requested timely.
4. **Should the bene contact the county before the date of the discontinuance and alleges to still be disabled for any reason, including DA&A, and is otherwise eligible, do not discontinue the case.**
 - Send full DED packet to SP-DED. MC 221 will be marked as follows: Item 8: "Initial Referral", Item 10: "DA/A Bene, Determination Needed Due to P.L. 104-121". Continue to provide benefits to the bene until SP-DED determination made.
 - If SP-DED finds bene to be not disabled, send standard discontinuance NOA informing bene that SP-DED can no longer find the bene to be disabled. Ensure that bene is provided SP-DED's PDN. If **Z53** denial (SP-DED adopted the SSA denial), send standard discontinuance NOA, with language similar to the MC 239SD (Denial of Benefits Due to a Federal Social Security Disability Determination) to explain the reason for the discontinuance and attach the MC Information Notice 13.
 - If SP-DED continues to find that bene is disabled, and bene remains otherwise eligible, continue to aid bene as disabled individual.
5. **Should the bene contact the county after the discontinuance date and alleges to continue to be disabled for any reason, including DA&A, take an application and complete a full DED packet.**
 - Send full DED packet to SP-DED. MC 221 will be marked as follows: Item 8: "Initial Referral", Item 10: "DA/A Applicant, Determination Needed Due to P. L. 104-121". Pend the application until SP-DED determination made.
 - If SP-DED finds applicant to be not disabled, send standard denial NOA informing applicant that SP-DED determined that he/she is not disabled and ensure that he/she is provided SP-DED's PDN. If **Z53** denial (SP-DED adopted the SSA denial), send MC 239SD and attach MC Information Notice 13.
 - If SP-DED approves disability and applicant is otherwise eligible, aid immediately.

* Any MNO Disabled applicant who received an SSA notice in 6/96 regarding termination of benefits by 1/1/97, must complete a full DED packet and await a SP-DED disability determination.

PROCESSING DRUG & ALCOHOL ADDICTION (DA&A) CASES
TERMINATED SSI/SSP (RAMOS)

●●●●●●●●

1. **Identifying DA&A Cases:**

New Ramos notices for any SSI case terminated due to cessation of disability, including DA&A. These names will appear on a special monthly Ramos listing to be mailed to the county Ramos coordinator.

MEDS QX screen will show disability cessation cases with a **Payment Status Code of N07**. The DA&A indicator is no longer available on the SDX or BENDEX.

Ask client if he/she received a notice in 6/96 advising that benefits will cease by 1/1/97. If yes, this is a DA&A case.*

2. **Do NOT give additional month of extended benefits while determining MNO eligibility.** Provide aid paid pending the hearing, if requested timely.
3. **Determine if eligible on some basis other than disability.** If eligible, aid immediately. If no other basis, go to next step.
4. **Send full DED packet to SP-DED.** If client is uncooperative and county has made two attempts, deny due to noncooperation.
5. **MC 221 will be marked as follows:** Item 8: "Initial Referral" and Item 10: "SSI Termination Due to DA/A, P.L. 104-121."--

(If unable to determine whether there is DA&A involvement, mark the MC 221 as follows:
Item 8: "Initial Referral" and Item 10: "SSI Termination.")
6. **Pend the application** until SP-DED determination made.
7. **If disability denied by SP-DED,** send standard denial NOA.
8. **If disability approved by SP-DED** and client is otherwise eligible, aid immediately.

* Any MNO Disabled applicant who received an SSA notice in 6/96 regarding termination of benefits by 1/1/97, must complete a full DED packet and await a SP-DED disability determination.