| Colorado Department of Health Care Policy and Financing<br>1570 Grant St., Denver, CO 80203-1818 | **NUMBER:**<br>HCPF 07-004 |
|---|---|
| | **CROSS REFERENCE:** |
| **DIVISION OR OFFICE:**<br>Operations and Finance Office | **DATE:**<br>01/30/2007 |
| **SUBJECT AREA:**<br>Disability Determination Application | |
| **SUBJECT:**<br>Medicaid Disability Application Transmittal<br><br>**TYPE:**<br>Procedure | **APPROVED BY:**<br><br>Lisa Esgar |

*HCPF Agency Letters can be accessed online at:*
*www.chcpf.state.co.us >>Reference Material >>Agency Letters*

**Purpose**:

This agency letter from the Colorado Department of Health Care Policy and Financing (HCPF) will define the processes around sending disability determinations to Consultative Examinations, LTD (CEL), the third-party vendor who makes disability determinations for the Department. Please distribute this agency letter to eligibility technicians who handle Medicaid cases.

**Background:**

The Department has received information from CEL that, on a regular basis, many of the applications for disability they receive are incomplete. As a result, these applications can be delayed. If an application is not complete when CEL receives it, it can often take several more weeks just to gather all the information they need before they can even begin the process of determining disability.

The most commonly missed items on the disability determination application include a correct determination of the client's Social Security Administration (SSA) status, correct identification of re-determinations, a correct application date with complete county technician contact information, and complete medical source information (this includes name, address, telephone number, dates, and reason for hospital, clinic, or doctor visit).

**Procedure:**

The Department is requiring the attached "Medicaid Disability Application Transmittal" be completed and included with each disability determination application. By including the completed transmittal, the necessary information will be present with every application to help insure a more timely determination by CEL.

Prior to the receipt of the disability determination, it is required to keep the client's medical information in the case file. Once the CEL decision is received by the county or Medical Assistance site, the determination and transmittal sheet should be retained in the case file; the medical information should be shredded after receipt of the decision.

**Effective Date:**

Immediately

**Contact Persons**:

Mark Lieberman
303-866-5600
Mark.Lieberman@state.co.us

Cindy Valdez
303-866-2321
Cindy.Valdez@state.co.us

**Attachments:**

Medicaid Disability Application Transmittal

Colorado Department of Health Care Policy & Financing
Eligibility Operations Section
1570 Grant St.
Denver, Colorado 80203

# MEDICAID DISABILITY APPLICATION TRANSMITTAL

**This transmittal cover sheet must be attached to the Medicaid Disability Application**

**NEW APPLICATION** ☐ **REDETERMINATION** ☐

**APPLICATION DATE:** ___/___/___ **REDETERMINATION DATE:** ___/___/___

**APPLICANT NAME:**_____ **SSN:**_____
(If no SSN, indicate verification of other documentation) ☐

**Before submitting this form, determine the status of any application to SSA for Disability Benefits.**
**Please check the application for completeness and make sure that it contains the following:**

- ☐ Complete county technician information (printed name, county, telephone and fax number, date, signature, supervisor name, and supervisor phone number)
- ☐ Date of Application
- ☐ Social Security Number (do not send applications where documentation criteria are not verified)
- ☐ Client address and telephone number - homeless is not acceptable, an address must be provided where the client or representative can receive mail (be sure to include contact name, address and telephone number, or parent information if child)
- ☐ Date of Birth
- ☐ Allegation of disabling condition (Section 2, A&B - the alleged condition must be specified or described; this may not be left blank, even in child applications)
- ☐ Complete listing of medical sources including name, address, telephone number, dates, and reason for hospital, clinic, or doctor visit (this information is critical to timely processing)
- ☐ Date last worked (if Client is working, use Section 8 - Remarks for a complete explanation of any special conditions or subsidies)
- ☐ Signed authorizations for release of medical records - one for each source.
- ☐ Signature on application
- ☐ Signed Power of Attorney or guardianship record if applicable

**County:**_____ **Date:**_____

**Mail completed application to:**

**Consultative Examinations, Ltd.**
**3100 S Sheridan Blvd., Suite 1C**
**Denver CO 80227-5528**