Please fax this form to CMSP Governing Board Office at (916) 649-2606 or (916) 244-0234

CMSP DDSD APPLICATION CHECKLIST

Client's Name:	**CIN#:**		**County use only** **Case #**
ACTION ITEM	**ACTION ITEM COMPLETED (DATE)**	**CMSP OFFICE NOTIFIED (DATE)**	**COMMENTS/OTHER FOLLOW UP**
☐ Request to complete DDSD packet sent to the client			
☐ DDSD packet not completed ❑ Application denied ❑ CMSP benefits discontinued ❑ Client is working full time ❑ Client has a pending SSA/SSI appeal			
☐ DDSD packet completed ❑ By client ❑ By authorized representative ❑ By worker			
☐ Completed DDSD packet sent to the State ❑ as presumptive request ❑ potential disability referral ❑ limited referral ❑ faxed as urgent request			
☐ Medical records sent to the State ❑ reflect member's current condition ❑ support connection to the cause of death ❑ partial records submitted			
☐ Retroactive Medi-Cal requested due to: ❑ Onset of condition ❑ Hospital stay ❑ Death of Member			
☐ Verification of death included: ❑ Death certificate ❑ Discharge summary ❑ MC 220 signed by next of kin			
☐ Following forms submitted: ❑ MC 221 ❑ MC 220 ❑ MC 223 ❑ MC 222 ❑ MC 272 ❑ DHS 7035 A/7035C ❑ HCFA-2728/CMS- 2728			
COUNTY USE		***CMSP USE ONLY***	
Worker's Name _____ Signature: _____ Supervisor's Name _____ Signature: _____ Worker's phone number: (_____)_____		Date received by CMSP: _____ Payment approved: ☐ Yes ☐ No Reason: _____ Signature: _____ Date: _____	