

## Medi-Cal Determination Eligibility Exception Request Form

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Enrollment worker must complete **Sections A and B**. Proof of Medi-Cal pending status or follow-up documentation must be faxed along with this form.

### A. ADAP Enrollment Worker (EW) Information

Enrollment Site Number	Date
Enrollment Site Name	Telephone
ADAP EW Name (Print)	EW ID Number
EW Phone Number	Fax Number

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### B. ADAP Client Information

Client Name	
SSN	DOB
<input type="checkbox"/> Original eligibility exception request <input type="checkbox"/> Follow-up eligibility exception request	

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### C. Ramsell Public Health Rx Use Only

Eligibility Start Date	Eligibility End Date	PMDC Systems™ ID
Received By/Extension	Date Received	Date Faxed to OA

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### D. OA/ADAP Use Only

Received By	Date Received	Date Returned to RPHRx
<input type="checkbox"/> <b>Approved:</b> <input type="checkbox"/> 30 day eligibility <input type="checkbox"/> 60 day eligibility <input type="checkbox"/> Other _____		
<input type="checkbox"/> <b>Denied:</b> _____		
<input type="checkbox"/> Provide documentation of completed Medi-Cal application, including any new action needed by client.		
<input type="checkbox"/> Must re-apply for Medi-Cal.		
<input type="checkbox"/> Provide documentation of compliance with required state Department of Social Services (DSS) consultative medical and/or psychiatric exam(s).		
<input type="checkbox"/> Contact State DSS disability analyst and obtain documentation that the client has fully complied with all DSS requirements (forms, exams, etc.) needed for a disability determination.		
<input type="checkbox"/> Provide copy of Social Security Administration determination letter.		
<input type="checkbox"/> Other _____		