TO: DIRECTORS, LOCAL DEPARTMENTS OF SOCIAL SERVICES
   DEPUTY/ASSISTANT DIRECTORS FOR FAMILY INVESTMENT
   FAMILY INVESTMENT SUPERVISORS

FROM: NETSANET KIBRET, EXECUTIVE DIRECTOR

RE: TDAP MEDICAL REPORT FORM 500-C

PROGRAMS AFFECTED: TEMPORARY DISABILITY ASSISTANCE PROGRAM
   (TDAP)

ORIGINATING OFFICE: OFFICE OF PROGRAMS

Summary

TDAP is a state-funded cash assistance program for a customer with an impairment that will last
at least three months and will prevent the customer from working. For the purposes of
Temporary Disability Assistance Program (TDAP), the type of impairment does not impact
program eligibility.

Action Required

The previous TDAP Medical Report Form 500-C captured whether a customer is unable to work
due to a mental illness, a learning disability, violent behaviors, or a visual impairment. The new
TDAP Medical Report Form 500-C form includes a new section whereby the healthcare provider
may indicate if a physical impairment other than a visual impairment prevents the customer from
working.

FIA updated the TDAP Medical Report Form 500-C as follows:

1) Adding a statement to capture whether a customer’s impairment prevents the customer
   from working regardless of the type of impairment (Section C continues to allow the
   healthcare provider to indicate the conditions for which the customer is treated); and
2) Updating Section D so that the healthcare provider can indicate if the customer can work regardless of the type of impairment.

Moving forward, case managers must use the current TDAP Medical Form 500-C when processing a TDAP application. All previous versions of the form are obsolete.

Note: The TDAP Medical Report Form 500-C is for TDAP cases only.

**Attachment**
TDAP Medical Report Form 500-C (revised 4.2019)

**Inquiries**
For policy-related questions, please complete the FIA Policy Information Request Form found on Knowledge Base as shown in the screenshot below.
Family Investment Administration: TDAP Medical Report Form 500-C

Department of Social Services

The Family Investment Administration is committed to providing access and reasonable accommodation in its services, programs, activities, education and employment for individuals with disabilities. If you need assistance or need to request a reasonable accommodation, please contact your case manager or call 1-800-332-6347.

Local District Office: ___________________________ Date: ___________________________

Case Manager: ___________________________ Phone Number: ___________________________

Customer’s Name: ___________________________ Customer ID#: ___________________________

The information provided on this form is used to determine eligibility for Maryland’s Temporary Disability Assistance Program (TDAP).

A. Patient Information:

Name of Patient: ___________________________ Date of Birth: ___________________________

Address: ____________________________________________________________

B. Dates of Examinations: First Visit: __________ Last Visit: ________________

C. Information About Impairment(s):

1. Provide the clinical diagnosis and name of impairment:

|________________________________________________________________________|
|________________________________________________________________________|
|________________________________________________________________________|

D. Health status:

1. Does this individual have a substance abuse issue? □ YES □ NO
   If yes, do other medical conditions exist in addition to substance abuse? □ YES □ NO

2. Does this individual suffer from a physical/mental/emotional impairment? □ YES □ NO
   If yes, is the impairment severe enough to prevent the patient from working, participating in a work, training or educational activity. □ YES □ NO

DHS/FIA 500-C revised 4/2019
3. Can the individual's impairment be expected to last at least 3 months? □YES □NO
   If yes, can the individual's impairment be expected to last at least 12 months or more?
      □YES □NO

Please give the length of time the patient's impairment is expected to last.

   ______/_____/____ to ______/_____/____
   Month    Day    Year    Month    Day    Year

E. Please add comments or clarifications here.


Signature of a health care provider with independent diagnostic authority, who is authorized to evaluate, determine impairment, and independently treat medical, mental and/or emotional disorders and conditions, and who is providing services according to the requirements of the appropriate professional board.

Signature: ___________________________ Print Name: ___________________________

Title: ___________________________ License #: ___________________________

Health Care Practice Name and Address:

__________________________________________________________________________

__________________________________________________________________________

Date: _______________ Phone ___________________________