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: _____

Health Provider

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

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 <u>is expected</u> 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_____