STATE OF MARYLAND  
DEPARTMENT OF HUMAN SERVICES  
FAMILY INVESTMENT ADMINISTRATION  

PUBLIC ASSISTANCE TO ADULTS DISABILITY CERTIFICATION FORM  

Public Assistance to Adults is a monthly payment of State funds to an individual who has been certified for a licensed assisted living program, a CARE home, or a Department of Health and Mental Hygiene (DHMH) rehabilitative residence.

SECTION I  REPRESENTATIVE PAYEE’S AGREEMENT  

In becoming a Representative Payee for _____________________________________________________________ (Name of Customer) _________________________________________________________________ (Customer ID)  

I understand and agree to the following:  

1.  To use the assistance payment to obtain shelter, food, clothing, etc. for the customer.  

2.  To provide some accounting so that the local department can know how the money was used.  

3.  To the best of my ability, assist the customer in meeting daily needs; help with ongoing problems, and to maintain a close contact with the customer.  

4.  To report to the local department any change in the financial circumstances of the customer of which I am aware; or any change in my relationship to the customer.

_________________________  ________________________  Representative Payee  ________________________  Date  

_________________________  ________________________  LDSS Case Manager’s Signature  ________________________  Date  

SECTION II  REHABILITATIVE RESIDENCE OR CARE HOME CERTIFICATION  

See Section III for Assisted Living placements  

The above-named client has been approved for service and will be placed in a CARE Home or Rehabilitative Residence facility.  

Facility: _____________________________________________________________  

Address: _____________________________________________________________  

Telephone No: _________________________________________________________  

Service Eligibility has been established for: _____________________________________________________________  

Level of Care: _________________________________________________________  

Planned Placement Date: _______________________________________________  

Mail Check to: _________________________________________________________  

Address: _____________________________________________________________  

Placement approved by: ________________________________________________  

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SECTION III MEDICAL REPORT

(Section III must be completed for PAA-Assisted Living applicants/recipient. This section also may be used for CARE Homes and Rehabilitation Residence applicants when an agency determination of need is not available.)

The information provided on this form may be used to determine eligibility for federal and state programs using Social Security disability criteria.

Please Print or Type

PATIENT INFORMATION:

Is a protective living arrangement necessary? □ Yes □ No

If yes, Justification for Protected Living Arrangement on page 3 must be completed

Name of Patient: ______________________
Name of Licensed Professional or Physician: ______________________
Address: _______________________________________________________
Specialty: _______________________________________________________
Phone: ______________________
Dates of Examination: First Visit: __________ Last Visit: __________
Presenting Symptoms: _____________________________________________
____________________________________________________________________
____________________________________________________________________

Diagnosis: ______________________ Onset Date: __________
Diagnosis: ______________________ Onset Date: __________

Hearing Limitations □ Yes □ No □ Minimal □ Moderate □ Extreme □ Severe

Speaking Limitations □ Yes □ No □ Minimal □ Moderate □ Extreme □ Severe

MENTAL HEALTH

Does the patient suffer from mental illness? □ Yes □ No

To the best of your knowledge does the patient exhibit any violent behaviors? □ Yes □ No

If yes, list below

____________________________________________________________________
____________________________________________________________________

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SECTION IV  VISUAL LIMITATIONS

Visual Field: OD ___________  OS ___________  VA ___________
(After corrections): OD ___________  OS ___________  VA ___________

PROGNOSIS AND RECOMMENDATIONS

Patient’s vision impairment LEVEL (PLEASE INDICATE BELOW)
Stable _____  Deteriorating _____  Capable of Improvement_____  Uncertain_____

Other recommendations (e.g., special eye consultation, special medical examination, low-vision aide, mobility training, prostheses, etc.; explain):

Justification for Protected Living Arrangement:
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

Additional Comments:
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________
____________________________________________________________________________________

Signature: ___________________________  Print Name: ___________________________
Title: _______________________________  Telephone: ___________________________
License or Federal ID#: ______________________
MA Provider#: ______________________  Date: ___________________________

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