

**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 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 \_\_\_\_\_