



Department of Human Resources
 311 West Saratoga Street
 Baltimore MD 21201

FIA ACTION TRANSMITTAL

Control Number: 13-12

Effective Date: Upon Receipt

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

Rosemary Malone
FROM: ROSEMARY MALONE, EXECUTIVE DIRECTOR

RE: REVISED MEDICAL REPORT FORM DHR/FIA 500

**PROGRAM AFFECTED: TEMPORARY CASH ASSISTANCE (TCA),
 TEMPORARY DISABILITY ASSISTANCE
 PROGRAM (TDAP), CHILD CARE SUBSIDY (CCS)**

ORIGINATING OFFICE: FIA OFFICE OF SPECIAL PROJECTS

SUMMARY: We revised the DHR/FIA 500 Health Form in order to provide a more positive focus on customer health. The form targets “what customers can do” rather than “what they can’t do.” The previous DHR/FIA 500 is obsolete.

Signature requirements have changed. While any licensed health provider may complete the new form, **a medical doctor must sign it** to verify the information. This includes specialists, including but not limited to psychiatrist, podiatrist, gastroenterologist, and cardiologist. Certified Registered Nurse Practitioners (CRNP) and Physician’s Assistants (PA) may also sign the form as medical providers – we understand that many serve as primary care providers for their patients.

Psychologists, licensed clinical social workers or therapists are all health providers and may complete the form and sign on the “Health Provider” line. However, **the “Medical Provider” line must be signed by a medical doctor.**

ACTION REQUIRED:

Begin using the new form upon receipt for all TCA, TDAP and CCS customers. Remember to give the customer a form for each medical provider providing treatment to the customer. At present, disability information is not required for FSP.

Until printed copies are available in the warehouse, case managers can print a copy from FIPNET under ONLINE FORMS.

ACTION DUE: Upon receipt.

ATTACHMENT

INQUIRIES: Please direct TCA questions to Mary Ellen Scalley at 410-767-7953 or mary.scalley@maryland.gov. Direct FSP inquiries to Rick McClendon at 410-767-7307 or rick.mcclendon@maryland.gov. TDAP inquiries should be directed to Wannise Hird at 410-767-7937 or wannise.hird@maryland.gov or to Yvette Lawrence-Hood at yvette.lawrence@maryland.gov or 410-767-7944. Direct CCS policy or procedures inquiries to Myra White-Gray at 410-767-7863 or myra.white-gray@msde.state.md.us. Direct system inquiries to the MSDE CCATS Help Desk at 410-767-7816 or MSDECCATS@msde.state.md.us.

Please remember that e-mail for FIA central staff converted to Google e-mail.

c: DHR Executive Staff
FIA Management Staff
Constituent Services
Help Desk
Child Care Subsidy Management Staff

MARYLAND DEPARTMENT OF HUMAN RESOURCES MEDICAL REPORT FORM

Department of Social Services Name and Address	
Return to LDSS by:	LDSS Fax Number:
Case Manager E-mail Address:	

Agency Use Only- CASE IDENTIFICATION	
CUSTOMER ID NUMBER	DIST
CASE NAME	

This medical report is needed to determine one or more of the following:

- Whether an individual is able to participate in employment and/ or training activities,
- Applicable, treatment plan(s) that could help the individual move towards employment,
- If the individual is a good candidate for disability assistance, and
- If applicable, whether the individual's pregnancy limits or precludes participation in employment or training activities.

COMPLETED BY THE DEPARTMENT OF SOCIAL SERVICES		
Customer's Name:	Customer's DOB:	Customer's Phone #:
Customer's Address (Street, City, Zip Code)		

Instructions to Health Provider

This form may be completed by a licensed health provider such as counselor, social worker, or mental health therapist, but must be agreed upon and signed by a licensed physician, psychiatrist, physician's assistant or a Certified Registered Nurse Practitioner.

Please complete the appropriate sections of this form and send (return to the patient or mail, fax or e-mail to case manager) to the Department of Social Services office above by _____.

Confirmation of Pregnancy
If this individual is pregnant, give expected delivery date. _____ / _____ / _____. Date
Note: If pregnancy does not affect this individual's ability to work, only complete health provider section of this form.

SECTION I HEALTH PROVIDER INFORMATION	PLEASE COMPLETE THIS ENTIRE SECTION.
Printed Name of Health Provider: _____	
License Number: _____	NPI Number: _____ (If Applicable)
Phone Number: (_____) _____	Address: _____
I certify that all of the information provided on this form is true, correct and complete to the best of my professional knowledge. I further certify that, the diagnosis and assessment related to this customer's health condition are based on his/her medical condition as determined by examination and knowledge of this customer's medical history.	
Signature of medical provider must be original or the form is invalid. Rubber stamp, label or other reproductions are not acceptable.	
_____	_____
Health Provider	Date
_____	_____
Signature of Medical Provider	Date

SECTION II EMPLOYABILITY

If BOX 1 IS SELECTED FOR THIS INDIVIDUAL, DO **NOT** COMPLETE SECTION III.

IF EMPLOYABLE, THIS INDIVIDUAL WILL HAVE A REQUIREMENT TO WORK OR PARTICIPATE IN TRAINING FOR _____ HOURS PER WEEK. PLEASE SELECT ONE OF THE FOLLOWING BASED ON YOUR BEST ESTIMATE OF THE INDIVIDUAL'S CURRENT CAPABILITIES:

1. **EMPLOYABLE –**

This individual is able to work or participate in training, on a sustained basis, for the hours that are required per week (see above).

with the following reasonable accommodations: _____

2. **LIMITED EMPLOYABILITY – Please check all that apply. Please also complete Section III.**

This individual is able to work or participate in training, on a sustained basis, for fewer than the hours that are required per week (see above).

Approximately how many hours can the individual participate per week? _____

with the following reasonable accommodations: _____

What is the recommended treatment plan to remediate this condition so this individual is able to work or participate in training, on a sustained basis, for the hours that are required per week (see above) or to increase the hours of participation?

Prescribed Medication

Therapy: _____ hours per week. Type: _____

Follow-up with specialist: Specialty _____ Name of Physician _____

Referral Made for Patient? _____

Is substance abuse present? ___Yes ___ No

If yes, do other medical conditions exist in addition to substance abuse? ___Yes ___ No

Other (describe): _____

This individual is expected to be limited from being able to work or participate in training for the number of hours indicated above on a sustained basis, beginning ____/____/____ and ending ____/____/____.
Date Date

3. **TEMPORARY INCAPACITY – Please also complete Section III.**

This individual's physical or mental condition precludes him/her from participating in any form of employment or training activity, on a sustained basis, at this time, but the condition is expected to improve within 12 months.

This individual's temporary incapacity is expected to prevent working or participation in training beginning ____/____/____ and ending ____/____/____.
Date Date

What is the recommended treatment plan to remediate this condition so this individual is able to work or participate in training, on a sustained basis, for the hours that are required per week (see above) or to increase the hours of participation?

Prescribed Medication

Therapy: _____ hours per week. Type: _____

Follow-up with specialist: Specialty _____ Name of Physician _____

Referral Made for Patient? _____

Other (describe): _____

4. **DISABLED – Please also complete Section III.**

This individual has a physical or mental condition that is expected to last for 12 months or more, and precludes any form of employment, on a sustained basis, of at least 30 hours per week. The individual is a candidate for Social Security Disability or Supplemental Security Income.

The disability begin date ____/____/____ and end date ____/____/____.
Date Date

SECTION III DIAGNOSIS (ES)

Include name of each diagnosis with ICD-9 code and description. Please explain how each diagnosis affects the customer's ability to work.

Primary Diagnosis:

Secondary Diagnosis:

Tertiary Diagnosis:

Other Diagnosis:

The individual is following the prescribed treatment plan.

_____ Yes _____ No _____ Don't know If No, indicate:

- Not taking medication as prescribed.
- Not following up with specialist
- Not eligible or appropriate for needed medication or treatment . Explain: _____

Other (describe): _____

