Rosemary Malone

DEPARTMENT OF HUMAN RESOURCES INCOME MAINTENANCE ADMINISTRATION 3 W. Saratoga Street l imore, Maryland 21201	IMA ACTION TRANSMITTAL
	EFFECTIVE DATE: Upon Receipt
ISSUANCE DATE: November 6, 1995	**CONTROL NUMBER:** IMA OPA #96-15

TO: DIRECTORS, LOCAL DEPARTMENTS OF SOCIAL SERVICES
DEPUTY/ASSISTANT DIRECTORS FOR INCOME MAINTENANCE
INCOME MAINTENANCE SUPERVISORS

FROM: KATHERINE L. COOK, ACTING EXECUTIVE DIRECTOR, IMA

RE: Revised 402 and 4204 Medical Forms

PROGRAMS AFFECTED: ALL PROGRAMS

ORIGINATING OFFICE: OPA/Disability Management Operations

SUMMARY

This transmittal will outline the use of revised medical report forms 402 and 4204. These revised forms will reduce time needed to determine individuals disabled for Income Maintenance programs and Supplemental Security Income. These revised forms will collect, at the beginning of the process, pertinent medical information regarding a person's disability to assist in making determinations quickly and accurately.

BACKGROUND INFORMATION

The 402 Medical Report form is used to obtain medical documentation for IMA programs. Two new forms, the 402A and 402B, are replacing the 402 medical form in order to more precisely target the kind of medical documentation needed for different programs.

A work group comprised of representatives of LDSS offices, DHR, DEAP, IMA and the medical community developed the new 402A Medical Evaluation Form and 402B Medical Report to address these needs. The 4204 Medical Assistance Program Vocational, Educational, and Social Data (VESD) form was also modified to provide more appropriate information for SRT decisions.

REVISED MEDICAL FORMS

402A Medical Report

The 402A Medical Report is used to verify pregnancy and deprivation for AFDC and Families and Children Medical Assistance (FAC). This form is also used to establish Project Independence

(PI) and FS work requirement exemptions and verify telephone and housekeeping needs. A copy of the 402A is attached. The 402A focuses on the specific information needed to determine work and training exemptions for Aid to Families with Dependent Children (AFDC) and Food Stamps (FS) individuals thus:

A. The 402A allows doctors to fill the form out quickly as it does not require the level of medical detail needed for the 402B.

B. The 402A has a Special Needs section that is not needed on the 402B.

C. The 402A has a Pregnancy verification section not needed on the 402B.

402B Medical Report

The 402B Medical Report is used to verify medical impairments for all Transitional Emergency Medical and Housing Assistance (TEMHA) and Federal Medical Assistance (ABD) applicants and recipients in a disabled category. A copy of the 402B is attached. The 402B focuses on gathering medical evidence needed to make disability determinations based on Social Security Administration (SSA) criteria for the following purposes:

A. The 402B can be used by the Disability Determination Service (DDS) as the initial source of medical documentation in making decisions concerning Supplemental Security Income (SSI) benefits for Transitional Emergency Medical and Housing Assistance (TEMHA) recipients. This will shorten the time DDS takes in making an initial SSI determination.

B. The 402B will be used by the Disability Entitlement and Advocacy Program (DEAP) to determine if the client should be referred to SSA to apply for SSI. This will expedite the referral process by eliminating referrals that are clearly not eligible for SSI. This will reduce the time it takes to obtain SSI decisions and improve the approval rate of those individuals referred.

C. The 402B will reduce the number of State Review Team (SRT) reviews returned to Local Departments of Social Services (LDSS) offices for additional information. This will reduce the time needed to make a final SRT disability determination for Medical Assistance (MA) purposes.

D. The 402B will reduce the number of remands at MA hearings as the 402B states the information gathered on the form will be used to determine disability using SSI criteria.

4204 Vocational, Educational, and Social Data form

The 4204 Medical Assistance Vocational, Educational, and Social Data form is used to provide data to assist the State Review Team in making disability determinations for applicants and recipients as blind or disabled under ABD Medical Assistance. A copy of the 4204 is attached.

ACTION REQUIRED

The revised forms should be completed and distributed following existing Local Department of Social Services and IMA program procedures.

Effective Date: Upon receipt of the new forms. The current 402 and 4204 may be used until supplies are depleted. An initial supply of the revised forms will be forwarded to LDSS offices when they are printed.

Please direct questions to David Baker, Disability Management Operations Manager, at (410) 767-7970.

cc: IMA Management Staff

MEDICAL EVALUATION FORM

_____ Department of Social Services

District: _____

Worker: _____

Phone #: _____

Date: _____

Client ID: _____

Pharmacy Assistance: ☐ NONE

☐ Active Case ☐ Application Taken

Part I: (To be completed by client)

Name: _____ Birth Date: ___/___/___ Last Grade Completed: _____

Address: _____ Telephone #: _____

_____

1. What illness or injury keeps you from working? _____

   Were you injured on the job? ☐ Yes ☐ No

2. What other health problems do you have? _____

I authorize the physician/health practitioner to release any information about my medical condition required by the state to determine eligibility for benefits.

Client's Signature: _____ Date: _____

P[illegible] (To be completed by Examining Physician/Health Practitioner)

The information you provide will be used to determine eligibility for assistance that is based on the physical or mental impairment of the client.

1. Date of current examination: _____
2. Physical Data: Height _____ Weight _____ Blood Pressure _____ Pulse _____
3. Has patient suffered serious accidents or injuries? ☐ Yes ☐ No

   If yes, nature of accident or injury _____ When? _____
4. Current Disorders: Estimated Date of Onset:

   _____ mo/yr _____

   _____ mo/yr _____
5. Based on your evaluation, is the patient impaired? ☐ Yes ☐ No
6. If yes: The impairment is expected to last from _____ to _____.
7. Is the patient able to work? ☐ Yes ☐ No
8. Is the patient able to attend school or participate in training programs? ☐ Yes ☐ No If no, through mo/yr: _____
9. Pregnancy confirmed? ☐ Yes ☐ No EDC _____ Date of Exam _____

   Received prenatal care? ☐ Yes ☐ No

SPECIAL MEDICAL NEEDS

10. Telephone or Housekeeping required because _____.

    Supervised care needed at the following level: ☐ Domiciliary Care ☐ Care in Home ☐ Protective Payee

    ☐ Other *(Specify)*: _____

    Comments: _____

My signature indicates that this information is correct to the best of my knowledge. I understand that if this form is not complete in it's entirety, it will be returned to the Local DSS and I will not be reimbursed.

[illegible]E _____ _____

Signature of Physician/Health Practitioner (Please Print)

ADDRESS _____ TELEPHONE # _____

LICENSE # _____ MA PROVIDER # _____ DATE _____

MEDICAL REPORT

_____ Department of Social Services

District: _____

Worker: _____

Phone #: _____

Date: _____

Client ID: _____

Pharmacy Assistance: ☐ NONE

☐ Active Case ☐ Application Taken

Part I: *(To be completed by client)*

Name: _____ Birth Date: ___/___/___ Last Grade Completed: _____

Address: _____ Telephone #: _____

_____

1. What illness or injury keeps you from working? _____

   Were you injured on the job? ☐ Yes ☐ No

2. What other health problems do you have? _____

I authorize the physician/health practitioner to release any information about my medical condition required by the state to determine eligibility for benefits.

nt's Signature: _____ Date: _____

Part II: *(To be completed by Examining Physician/Health Practitioner*

Date of Examination: _____ First Visit: _____ Last Visit: _____

Please provide detailed responses regarding the patient's impairment(s), based on the most recent examination or treatment record. Copies of laboratory reports, xray reports, EKG tracings, and other studies that support a finding of disability should accompany this report. Please continue responses on a separate sheet, if needed, attaching it securely to this form. The information provided may be used to determine eligibility for federal programs using Social Security disability criteria.

1. **DIAGNOSIS:** Please state the major or chief physical and/or mental impairment(s), that may result in the inability to perform work, activity, or routine activity of daily living.

		Estimated Date of ONSET
_____	ICD-9-CM _____	_____
_____	ICD-9-CM _____	_____
_____	ICD-9-CM _____	_____
_____	ICD-9-CM _____	_____

2. **HISTORY OF IMPAIRMENT(S):** Include at a minimum; a) description of the pertinent history of the impairment; b) treatment and hospitalization, including a description of those factors that limit the patient's ability to function. Include all current medications by drug name and dosage.

_____

_____

_____

_____

MEDICAL REPORT

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3. **REVIEW OF SYSTEMS:** Present all pertinent findings in making a differential diagnosis or evaluating the severity of the impairment, including a family history, and a description of the use of alcohol, tobacco, or any non-prescription medication.

_____

_____

_____

_____

4. **PHYSICAL FINDINGS:** Include your observations and significant findings related to the impairment(s). This must include all information as requested, and a description of the patient's general appearance and behavior during the examination. Present specific findings objectively, for example, range of motion of a joint, should be reported in degrees.

Height: _____ Weight: _____ Blood Pressure: _____ Pulse: _____ Respiration: _____

Muscle Strength (1/5 to 5/5): UE _____ LE _____

_____

_____

_____

_____

5. **LABORATORY/XRAY/TEST RESULTS:** Include the actual values for laboratory tests, xray reports, electrocardiograph and or spirometric tracings.

_____

_____

6. **TREATMENT AND RESPONSE:** Include past treatment and response, if known; projected treatment and anticipated response, include all medication and/or recommended therapy.

_____

_____

_____

Based upon your evaluation is this patient impaired? ☐ Yes ☐ No If yes, duration from _____ to _____

Is the patient able to work? ☐ Yes ☐ No

TO THE PHYSICIAN/HEALTH CARE PRACTITIONER COMPLETING THIS FORM:

My signature indicates that this information is correct to the best of my knowledge. I understand that if this form is not completed in its entirety, it will be returned to me by the local department and I will not be reimbursed.

Name: _____ Printed Name: _____

Address: _____ Title: _____

_____ License #: _____

MA Provider # _____

Telephone: _____ Date: _____

MEDICAL ASSISTANCE PROGRAM
VOCATIONAL, EDUCATIONAL, AND SOCIAL DATA

_____ Dept. of Social Services

(To be completed by caseworker in the interview with the applicant)

Client ID#	D.O.B.	Sex

Name	Social Security #

I. EMPLOYMENT HISTORY

Usual Occupation	Last Day of Work

Other Types of Work	What is applicant's opinion of his/her ability to work? _____

Last place of employment:	Dates	Reason for Leaving

Last place of employment:	Dates	Reason for Leaving

II. EDUCATION AND TRAINING

Can applicant read and write English? ☐ Yes ☐ No

Highest grade completed in school

Type of Diploma

GED? ☐ Yes ☐ No

Attended College or technical school? ☐ Yes ☐ No *If yes, name Major or Specialty:* _____

Degree or Certificate

If ever in college or technical school for some time, state semester hours spent school. _____ hrs.

Military? ☐ Yes ☐ No *If yes, name branch:* _____

III. SOCIAL DATA

Current living arrangement: ☐ Alone ☐ With others ☐ Chronic or other hospital ☐ Private Home ☐ Own Home/Apartment

Does applicant take care of his/her own personal needs? ☐ Yes ☐ No

Does the applicant need personal assistance? ☐ Yes ☐ No *If yes, what type needed:* _____

IV. PHYSICAL DATA

Briefly describe applicant's physical appearance and daily activities:

Does the applicant have difficulty: ** Indicate degree of difficulty

Walking	☐ Yes	☐ No	☐ None	☐ Minimum	☐ Moderate	☐ Extreme
Standing	☐ Yes	☐ No	☐ None	☐ Minimum	☐ Moderate	☐ Extreme
Lifting	☐ Yes	☐ No	☐ None	☐ Minimum	☐ Moderate	☐ Extreme
Bending	☐ Yes	☐ No	☐ None	☐ Minimum	☐ Moderate	☐ Extreme
Climbing	☐ Yes	☐ No	☐ None	☐ Minimum	☐ Moderate	☐ Extreme

Does the applicant use a device such as cane, wheelchair, crutches, or other prostheses? ☐ Yes ☐ No

If yes, explain: _____

V. REHABILITATION AND DISABILITY COMPENSATION REFERRALS

Has the applicant been referred to a vocational rehabilitation program? ☐ Yes ☐ No _____

If yes, Name and address of referring agency: _____

and *Name and address of rehabilitation agency:* _____

Has the applicant applied for any related compensation, e.g., Social Security, SSI, VA, Workmen's Compensation ? ☐ Yes ☐ No

If yes, complete the following:

TYPE	DATE APPLIED	DECISION (i e., Eligible, Ineligible or Pending)

If applicant was determined ineligible for Social Security and/or Supplemental Security Income, state the reasons why: _____

Caseworker Signature

Date

Printed Name of Worker

Supervisor's Signature

Date

Telephone Number of Caseworker