_________________Department of Social Services

MEDICAL REPORT FORM 500

Local District Office: ______________________________________ Date: ______________________

Case Manager: ______________________________ Phone Number: ______________________________

Customer's Name: _________________________________ Customer ID#: _________________________

The information provided on this form may be used to determine eligibility for federal and State programs and participation in employment or training programs.

A. Patient Information:

Name of Patient: _____________________________________ Date of Birth: ______________________

Address:____

Dates of Examinations: First Visit:_____________________ Last Visit:______________________________

Presenting Symptoms:____
____
____

B. Physical Limitations:

In terms of the patient's ability to perform work during an 8-hour day **o**r attend classes **or a** training activity with normal breaks, the patient can:

Activity	Unknown	No Restrictions	Never	1 hr	2 hrs	3 hrs	4 hrs	5 hrs	6 hrs	7 hrs	8 hrs
Sit											
Stand											
Walk											
Climb											
Bend											
Squat											
Reach											
Crawl											

Circle the **HEAVIEST** weight the patient can lift/carry.

Less than 10 lbs. 10 lbs. 20 lbs. 25 lbs. 50 lbs. 100 lbs. More than 100 lbs.

How do environmental factors such as dust, chemicals, heat and cold, limit the patient's activities?______
____
____
____

Is substance abuse present? ☐ **YES** ☐ **NO**
If yes, do other medical conditions exist in addition to substance abuse? ☐ **YES** ☐ **NO**

C. Mental Status Information:

Does the patient suffer from a mental illness? ☐ **YES** ☐ **NO**

To the best of your knowledge does the patient have any learning disabilities? ☐ **YES** ☐ **NO**

To the best of your knowledge, does the patient exhibit any violent behaviors? ☐ **YES** ☐ **NO**
If yes, please provide additional information at the end of this form.

DHR/FIA 500 (Obsoletes the use of the DHR/FIA 402b, 402w and 701 for FIA programs)

Does the patient have an impairment or combination of impairments that interfere with his or her ability to function independently, appropriately and effectively on a continuous basis? **YES_____ NO _____**

Does the patient have a visual impairment or disease that limits or interferes with his or her ability to function independently, appropriately and effectively on a continuous basis? **YES_____ NO____**

FUNCTIONAL LIMITATIONS (degree of restriction or difficulty)	**DEGREE OF LIMITATION**			
Daily living activities	☐ None	☐ Mild	☐Moderate	☐ Extreme
Maintaining social functioning	☐ None	☐ Mild	☐ Moderate	☐ Extreme
Maintaining concentration	☐ None	☐ Mild	☐ Moderate	☐ Extreme

Based upon your evaluation, has the patient's medical condition or visual impairment been on-going?
YES_____ NO____
Can it be expected to last at least 12 months or more? **YES** ☐ **NO** ☐

If yes, please give the length of time the patient's medical condition is expected to last.

_____/_____/_____ To _____/_____/_____
Month Day Year Month Day Year

Is the patient's medical condition expected to result in death? **YES** ☐ **NO** ☐

Does the patient's medical condition or visual impairment limit his or her ability to work? **YES** ☐ **NO** ☐

If **yes**, please give the duration. ______/______/______ To ______/______/______
Month Day Year Month Day Year

Does the impairment limit the patient's ability to attend school or training? **YES** ☐ **NO** ☐

If **yes**, please give the duration.______/______/______ To ______/______/______
Month Day Year Month Day Year

If yes, provide the number of hours the patient's participation in work, school or training will be limited to per day: ____________________

D. If this medical form is being completed for a child, does the child's condition require the parent to be in the home full time to provide care for the child? **YES** ☐ **NO** ☐

E. Additional Comments:____

____

____

Signature:______________________________ Print Name:__________________________________

Title:____________________________________ License #:________________________________

Medical Practice Name and Address: ____

____

MA Provider#:____________________ Federal ID # or Social Security #: ______________________

Date: _________________________________