

Appendix B
EAEDC Medical Report Form



General Instructions to Medical Providers for Completing an EAEDC Medical Report Form Massachusetts Department of Transitional Assistance

Physicians:

Your patient has applied for cash and medical assistance under the Emergency Aid to the Elderly, Disabled and Children (EAEDC) program as disabled. To be eligible, your patient must file an EAEDC Medical Report with the Department. Because the medical data included in the report (diagnosis, clinical findings, test results) will be used by the Department to determine disability, it is essential that when you complete the report you supply *all relevant information*.

There are three methods for establishing disability for purposes of EAEDC. The Medical Report asks for an opinion, based on your diagnosis and findings, of whether your patient meets the disability definition (below). The Department's Medical Review Team will review this opinion in light of the medical data you and your patient provide.

Disability: A physical or mental impairment, or combination of impairments, that

- (1) affects the patient's ability to work;
- (2) is expected to last for 60 or more days; and
- (3)
 - (a) substantially reduces or eliminates the patient's ability to support him-or herself when consideration is given to his or her functional capacity, age, education and work experience; or
 - (b) meets or is equal in severity to an impairment listed in the Department's Medical Standards (Department Regulation 106 CMR: 320.210); or
 - (c) meets or is equal in severity to an impairment listed in SSI Listing of Impairments as specified in 20 CFR, Part 404, Subpart P. Appendix I.

Important

- Complete the Medical Report form in full.

If you need a copy of the Department's Medical Standards, Fax your request using your letterhead which includes your address to (617) 727-0167 or telephone (617) 348-5299 and leave a message.

If you have any questions concerning the completion of the Medical Report or the type of information required to establish disability, telephone 1-800-888-3420.

- Attach examination findings and diagnostic tests to the Medical Report to support your opinions.
- Refer to the Department's Medical Standards and the SSI Listing of Impairments which require that a diagnosis be supported by specific clinical findings.
- More than one doctor may complete and sign the Medical Report.
- A patient may submit more than one Medical Report.

The Department will pay for the medical evaluations needed to complete an EAEDC Medical Report, including diagnostic tests, through its regular medical billing system (MMIS). Please use your regular MassHealth Provider Number when submitting invoices for these services.



**Emergency Aid to the Elderly, Disabled
and Children Medical Report**
Massachusetts Department of Transitional Assistance

Physician/Community Health Center

Telephone Number

Address (Street, City/Town/State/ZIP)

Physicians: This medical report is needed to verify whether the patient has a physical and/or mental impairment(s) that substantially reduces or eliminates the patient's ability to support him or herself. To complete this medical report refer to the General Instructions for Completing an EAEDC Medical Report, the Department's medical standards, and SSI Listing of Impairments. Complete the medical report in its entirety, sign it and return it to the patient or mail to:

Worker's Name (please print)

Transitional Assistance Office

Address (Street, City/Town/State/ZIP)

by ____/____/____.

Call 1-800-888-3420 with any questions you may have regarding the completion of this report.

Patient's Name (please print)

____/____/____
Date of Birth

Social Security Number

Complete Address (Street, City/Town/State/ZIP)

Telephone Number

Does the patient speak and read English? yes no If no, contact to interpret.

Name

Telephone Number

Relationship

Authorization to Release Information

I hereby authorize the release of the medical/psychiatric information requested in this medical report, in writing or by telephone or fax, to the Massachusetts Department of Transitional Assistance and/or its medical review team.

Signature

____/____/____
Date

(A photocopy of this authorization may be substituted for the original.)

Important: If this medical report contains information regarding tests for the presence of HTLV-III antibody or antigen, the health care provider must obtain a written informed consent for the release of such information pursuant to Massachusetts General Law Chapter III Section 71.

Part I – Conclusions

A. Disability

1. no physical and/or mental impairment(s) affecting ability to work
2. has a physical and/or mental impairment(s) affecting ability to work which is not expected to last sixty (60) days or more
3. has a physical and/or mental impairment(s) that meets or is equivalent to the Department's Medical Standards or the SSI Listing of Impairments and is expected to last:
 60 to 90 days 3 to 6 months 6 to 12 months more than one year
4. has a physical and/or mental impairment(s) that does not meet the Department's Medical Standards or the SSI Listing of Impairments, but does affect ability to work and is expected to last:
 60 to 90 days 3 to 6 months 6 to 12 months more than one year

B. Examination Date

1. Date of most recent examination ___/___/___ (should be within 30 days of date of report).
2. Is the patient's condition chronic and no improvement is expected? Yes No

(See page 3 for standards)

Part II – Clinical Information

A. Diagnosis/Findings

For examples of the types of clinical details needed, refer to the Department's Medical Standards and the SSI Listing of Impairments which require that a diagnosis be supported by specific clinical findings.

| Diagnosis | Supporting Symptoms | Pertinent Findings | Supportive Diagnostic Tests and Dates of Findings |
|--|---------------------|--------------------|---|
| Primary | | | |
| Onset date ____/____/____ Date of Dx ____/____/____ | | | |
| Secondary | | | |
| Onset date ____/____/____ Date of Dx ____/____/____ | | | |
| Other | | | |
| Onset date ____/____/____ Date of Dx ____/____/____ | | | |

Patient's height _____ weight _____ blood pressure _____

Are any of these conditions a result of an accident or injury? Yes No

Have you examined or treated this patient before? Yes No

B. Medical/Psychiatric History

Include hospitalizations and/or substance abuse history within the past five years. List facilities, dates and reasons for admission(s).

C. Additional Impairment(s)

Does the patient have any other impairment(s) that may affect the patient's ability to work? If so, list the impairment(s) and if you know the physician who diagnosed or treated the patient for it, provide the physician's name, address and telephone number.

D. Treatment

List planned follow-up treatment and frequency. If no follow-up treatment is planned, indicate so.

| Treatment | Frequency | Duration |
|-----------|-----------|----------|
| | | |

E. Medication

List medication(s), strength, frequency and side effects.

| Medication | Strength | Frequency | Side Effects |
|------------|----------|-----------|--------------|
| | | | |

**Part III — Assessment of Functional Capacity
(complete A and B as appropriate)**

A. Physical Activities

Indicate if patient can sustain the following activities on a regular basis.

| | | | |
|--|--|--|---|
| 1. Patient: | | | |
| can walk: | <input type="checkbox"/> no restrictions | <input type="checkbox"/> less than 100 ft. | <input type="checkbox"/> about 500 ft. <input type="checkbox"/> 1/4 mile |
| can stand daily for: (with breaks every two hours) | <input type="checkbox"/> 8 hours | <input type="checkbox"/> 6 hours | <input type="checkbox"/> 4 hours <input type="checkbox"/> 2 hours <input type="checkbox"/> less than 1 hour |
| can sit daily for: (with breaks) | <input type="checkbox"/> 8 hours | <input type="checkbox"/> 6 hours | <input type="checkbox"/> 4 hours <input type="checkbox"/> 2 hours <input type="checkbox"/> less than 1 hour |
| can stand and sit intermittently for _____ hours (with breaks) | | | |
| can bend/stoop (how often per day) | <input type="checkbox"/> constantly | <input type="checkbox"/> frequently | <input type="checkbox"/> occasionally <input type="checkbox"/> never |
| has a significant restriction of | <input type="checkbox"/> arms <input type="checkbox"/> legs | <input type="checkbox"/> reaching <input type="checkbox"/> gross motor | <input type="checkbox"/> handling <input type="checkbox"/> fine motor <input type="checkbox"/> none <input type="checkbox"/> manipulation |
| can reasonably be expected to | lift frequently <input type="checkbox"/> no limit <input type="checkbox"/> 50 lbs. <input type="checkbox"/> 20 lbs. <input type="checkbox"/> 10 lbs. <input type="checkbox"/> cannot lift 10 lbs. | lift/carry occasionally <input type="checkbox"/> no limit <input type="checkbox"/> 50 lbs. <input type="checkbox"/> 20 lbs. <input type="checkbox"/> 10 lbs. <input type="checkbox"/> cannot lift/carry 10 lbs. | |
| 2. Other restrictions, if any, on physical or daily living activities | | | |
| | | | |
| | | | |

B. Mental Activities

Indicate if patient can sustain the following activities on a regular basis.

| Activities | No limitations | Slightly limited | Moderately limited | Markedly limited |
|---|----------------|------------------|--------------------|------------------|
| 1. Patient has the ability to: | | | | |
| a. remember and carry out simple instructions | | | | |
| b. maintain attention and concentration in order to complete tasks in a timely manner | | | | |
| c. make simple work-related decisions | | | | |
| d. interact appropriately with co-workers and supervisors | | | | |
| e. work at a consistent pace without extraordinary supervision | | | | |
| f. respond appropriately to changes in work routine or environment | | | | |

2. What is the overall effect of the patient's medication on the above activities?

Comments

Print Physician's Name _____

Telephone Number _____

Complete Address (Street/City/Town/State/ZIP) _____

Physician's Signature _____

Date ____/____/____

*MassHealth Provider Number _____

*If this medical exam is given in a community health center, the community center's MassHealth Provider Number is to be used.

You will be contacted if the Department's medical review team has questions about this medical report. It is important to respond to all medical review team inquiries.

