APPENDIX A

EAEDC MEDICAL REPORT FORM

PATIENT INFORMATION
_____ Last Name _____ First Name
_____ Date of Birth _____ Social Security Number
_____ Address (Street, City, State, Zip Code)
_____ _____ Telephone Number

Massachusetts Department of Transitional Assistance

EAEDC Medical Report

General Instructions to Medical and Mental Health Care Providers

Your patient has applied for cash and medical assistance under a DTA program as disabled. To be eligible, your patient must file an **EAEDC** Medical Report so that eligibility can be determined. Regulations for a disability determination require that a diagnosis be supported by specific clinical findings. The medical data provided by you in the report (clinical findings, diagnosis, test results) will be used by DTA to determine disability.

For these purposes, an individual is disabled if he or she has an impairment or combination of impairments that is expected to last 60 days or more and that substantially reduces or eliminates the applicant's or client's ability to support himself or herself.

If you need a copy of DTA's regulations regarding a disability determination, telephone (617) 348-5299 and leave a message or refer to DTA's regulations by visiting the Mass.gov website at:
http://www.mass.gov/eohhs/docs/dta/g-reg-320.pdf

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

- The EAEDC Medical Report must be signed by a Competent Medical Authority. Please refer to page **10** for details before proceeding further.
- The EAEDC Medical Report must include an objective report of clinical findings and current functioning.
- It is essential that, when you complete the EAEDC Medical Report, you supply *all relevant information.*
- Complete the EAEDC Medical Report in full with respect to the conditions that are relevant to the patient. Sign and return it to the patient or mail it to: DTA Document Processing Center, P.O. Box 4406, Taunton MA 02780-0420, or fax to (617) 887-8765 indicated on page **11**.

Call UMASS/Disability Evaluation Services (DES) at 1-800-888-3420 with questions you may have regarding the completion of this report.

Department of Transitional Assistance (DTA) and Disability Evaluation Services (DES) Medical Records Release Form

Sign this form to let your medical and mental health care provider share information with UMASS/Disability Evaluation Services (DES).

HOW TO FILL OUT THIS FORM

Your medical and mental health care provider will only send medical records to UMASS/Disability Evaluation Services if you fill out the form right. Follow these steps:

1. **Fill out this Medical Records Release Form before you give the EAEDC Medical Report to your medical and mental health care provider. A medical and mental health care provider is a doctor, nurse, psychologist, psychiatrist, therapist, nurse practitioner, physical therapist, chiropractor, hospital, health center, clinic or other medical or mental health provider.**
2. **Fill out every section of the Medical Records Release Form. DES can only get your medical information if you fill out every section. DES will decide your case without the information if DES cannot get it.**
3. **Sign and date the Medical Records Release Form with a pen. Do not sign with a pencil. Sign the form yourself. You cannot use a copy or stamp of your signature**.

SECTION I
Your Name and Address

Print name of applicant/client:	Telephone Number:	
Street address:		Date of birth:
City/Town	State:	ZIP:

SECTION II
Health Care Provider's Name and Address

Name of doctor, nurse, psychologist, psychiatrist, therapist, nurse practitioner, physical therapist, chiropractor, hospital, health center, clinic or other medical or mental health provider.		
Street address:		
City/Town	State:	ZIP:
Telephone Number: (		

(continued on back) ▶

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SECTION III

I allow the medical and mental health care provider listed in Section II to share with DTA and Disability Evaluation Services (DES):

- my medical records;
- other information about my time in a hospital;
- other information about any of my medical care.

I allow the medical and mental health care provider to share all information about my health. This includes information about:

- my mental health;
- my AIDS/HIV status;
- drug and alcohol abuse;
- how my health problems affect my ability to work;
- how my health problems affect what I do every day.

✓ **Check here if you do NOT allow the medical and mental health care provider to share your AIDS/HIV status:** ☐

SECTION IV

I understand that I can cancel this permission at any time. I can cancel this permission by sending a letter to my medical and mental health care provider. I understand that this permission ends six months from the date I sign this Medical Records Release Form, if I do not cancel it before then.

I understand that my medical and mental health care provider may send information to DTA and DES before I cancel my permission. I understand that my medical and mental health care provider cannot get the information back after sending it.

I understand that it is my choice to let my medical and mental health care provider share medical information with DTA and DES. I do not have to give permission. I also understand that DTA and DES will decide about my disability without the information if I do not let my medical and mental health care provider share it.

SECTION V

Signature of applicant/client:	Date:

If the person signing this form has legal authority to act for the applicant/client (such as a legal guardian), give us the following information:

Signature of person completing this form:	
Printed name:	Date:
What kind of authority do you have to sign for the applicant/client?	

Medical Standards

You may reference the Department's Medical Standards at 106 CMR 320.200 or at:
http://www.mass.gov/Eeohhs2/docs/dta/g_reg_320.pdf

Check the standards that apply to this patient's impairment(s):			
	Musculoskeletal System		Endocrine System
	Special Senses & Speech		Multiple Body System
	Respiratory System		Neurological System
	Cardiovascular System		Mental Disorder
	Digestive System		Immuno - suppressive Disorder
	Genitourinary System		Neoplastic Diseases - Malignant
	Hemic & Lymphatic Systems		Medically Equivalent/Combination of Impairments
	Skin		

Part I – Medical Information

IA. Physical Examination - Please include both normal and abnormal findings. (For mental health or cognitive conditions only, skip to Part II.)	
Date of exam: ____/_____/_____ (Must be within 30 days of this report being completed.)	Have you seen this patient before?
Patient complains of:	
Medical history - Include hospitalizations within the past five years. (List facilities, dates and reasons for admission(s):	

Temperature:	Blood Pressure:	Height:	Weight:	Pulse:	Respiratory Rate:

IA. Physical Examination - Please include both normal and abnormal findings. (For mental health or cognitive conditions only, skip to Part II.)	
General appearance:	
HEENT:	
Cardiovascular system:	
Lungs:	
Abdomen:	
Musculoskeletal exam (Please include range of motion of affected joints.):	
Neurological system • Reflexes: • Motor Strength: • Sensation (light touch, pin prick, vibration and position): • Cranial Nerves: • Cerebellar function (include observed ambulation): • Mental status (i.e., oriented X3, confused, etc.)	
Skin:	
Additional findings not noted above (i.e. lab findings, x-rays, MRI's, referrals with dates):	
Is the patient's condition chronic? ❒ no ❒ yes If the patient's condition is chronic, is improvement expected? ❒ no ❒ yes If improvement is expected, what is the year and month that improvement is expected? _____	
Additional comments:	

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I B. Physical Examination -Assessment and Plan		
Diagnosis	List of Medications	Treatment Plan
Diagnosis: Onset Date: ____/___/_____ If known, date of diagnosis: ____/___/_____ Anticipated duration:		
Diagnosis: Onset Date: ____/___/_____ If known, date of diagnosis: ____/___/_____ Anticipated duration:		
Diagnosis: Onset Date: ____/___/_____ If known, date of diagnosis: ____/___/_____ Anticipated duration:		
Diagnosis: Onset Date: ____/___/_____ If known, date of diagnosis: ____/___/_____ Anticipated duration:		
Diagnosis: Onset Date: ____/___/_____ If known, date of diagnosis: ____/___/_____ Anticipated duration:		

Which of the above, if any, is a result of accident or injury?

If applicable, please give a general description:

Part II – Mental Health and Cognitive Information

II A. Mental Health and Cognitive Examination Please include both normal and abnormal findings. (If no mental health or cognitive conditions, skip to Part III.)	
Date of exam: _____/_____/_____ (Must be within 30 days of this report being completed.)	Have you seen this patient before?
Patient complains of:	
History- Include hospitalizations within the past five years. List facilities, dates and reasons for admission(s).	
Current clinical signs and symptoms (i.e., sleep disturbance, anhedonia, panic attacks, flashbacks, nightmares, etc.):	
Appearance/attitude/behavior:	
Orientation (person, date, place):	
Mood and affect:	
Speech (pressured, paucity of speech, etc.):	
Thought process (dissociation, blocking, flight of ideas, etc.):	
Thought content (phobias, obsessions, delusions, ideas of reference, etc):	
Perceptions (i.e., hallucinations):	
Cognition (level of intellectual function, ability to concentrate, ability to learn):	
Additional comments:	

II B. Mental Health and Cognitive Examination - Assessment and Plan		
Diagnosis	List of Medications	Treatment Plan
Diagnosis: Onset Date: ____/___/_____ If known, date of diagnosis: ____/___/_____ Anticipated duration:		
Diagnosis: Onset Date: ____/___/_____ If known, date of diagnosis: ____/___/_____ Anticipated duration:		
Diagnosis: Onset Date: ____/___/_____ If known, date of diagnosis: ____/___/_____ Anticipated duration:		
Diagnosis: Onset Date: ____/___/_____ If known, date of diagnosis: ____/___/_____ Anticipated duration:		
Diagnosis: Onset Date: ____/___/_____ If known, date of diagnosis: ____/___/_____ Anticipated duration:		

Which of the above, if any, is a result of accident or injury?

If applicable, please give a general description:

Part III – Additional Impairments

III. Additional Impairments
List any other impairment(s) that may affect the patient's ability to work. List the impairment(s) and any resulting limitations in functioning. If you know the medical and mental health care provider who diagnosed or treated the patient for it, provide the medical and mental health care provider's name, address and telephone number.

Part IV – Effect on Activities of Daily Living

IV. In as much as you know, does the patient's medical, mental health, and/or cognitive condition(s) impact ability to perform daily activities such as:		
Activity	**Check if yes**	**If yes, please describe the impact on daily activities:** (Attach additional page if needed)
Personal hygiene and dressing		
Ordinary housework		
Food shopping		
Driving		
Managing medications		
Using a computer		
Placing an emergency phone call		
Visiting family and/or friends		
Other		

Part V – Conclusions

Does this patient have a physical, mental health, or cognitive impairment(s) affecting ability to work?
(Check one of the following.)

❒ **No,** this patient does not have a physical, mental health, or cognitive impairment(s) affecting his or her ability to work.

❒ **Yes,** this patient does have a physical, mental health, or cognitive impairment(s) affecting his or her ability to work which is NOT expected to last sixty (60) days or more.

❒ **Yes,** this patient does have a physical, mental health, or cognitive impairment(s) affecting his or her ability to work AND the impairment(s) is expected to last :

❒ 60 to 90 days ❒ 3 to 6 months ❒ 6 to12 months ❒ more than a year

❒ **Yes**, this patient has a physical, mental health, or cognitive impairment(s) that does not meet or equal the Department's Medical Standards or the SSI Listing of Impairments but does affect his or her ability to work AND the impairment(s) is expected to last :

❒ 60 to 90 days ❒ 3 to 6 months ❒ 6 to12 months ❒ more than a year

Part VI – Signature of *Competent Medical Authority*

This Medical Report must be signed by a ***Competent Medical Authority.*** Per 106 CMR 701.600, a Competent Medical Authority is a physician, osteopath, nurse practitioner, or psychologist licensed by the Commonwealth of Massachusetts, including a physician or psychiatrist from a Veterans Administration Hospital or clinic or from a Massachusetts Department of Mental Health facility or, for the limited purpose of diagnosing pregnancy and pregnancy-related incapacity, a nurse-midwife or who meets the educational and certification requirements mandated by Massachusetts state law and/or regulations.

_____ _____
Printed Name of *Competent Medical Authority* Telephone Number

_____
Address (Street, City, State, Zip Code)

_____ _____
Signature of *Competent Medical Authority* Date

You may be contacted by someone at UMASS/Disability Evaluation Services (DES) if there are questions about this Medical Report. It is important to respond to these inquiries as they may relate to your patient's eligibility for benefits through the Department of Transitional Assistance.

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THIS REPORT MUST BE COMPLETED IN ITS ENTIRETY, SIGNED AND RETURNED TO THE PATIENT OR MAILED TO:

DTA Document Processing Center,
P.O. Box 4406
Taunton, MA 02780-0420
Or
Fax to (617) 887-8765

By: _____/_____/_____