General Instructions to Medical Providers for Completing an EAEDC Medical Report

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: An 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: 320.200); 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. This report must include an objective report of clinical findings and current functioning. (You should also refer to the attached General Instructions to Medical Providers for Completing an EAEDC Medical Report.) THIS REPORT MUST BE COMPLETED IN ITS ENTIRETY, SIGNED AND RETURNED TO THE PATIENT OR MAILED 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 the person below to interpret.

Name _____ Telephone Number _____ Relationship _____

Authorization to Release Information

I hereby authorize the source named on Page 1 to give the following information to the Department of Transitional Assistance (DTA) and its agent, the Disability Evaluation Service: all medical records or other information about my treatment, hospitalization, and/or outpatient care for my condition including:

- psychological/psychiatric impairments
- how my impairments affect activities of daily living and my ability to work
- other: _____
- AIDS/HIV
- drug and alcohol abuse

Check here if you do not authorize the release of information about your AIDS/HIV status: ❒

Any medical information that the health-care provider releases to DTA and the Disability Evaluation Service will continue to be protected by federal privacy laws.

This permission to release medical information to DTA and the Disability Evaluation Service expires six months from the date you sign this release form, unless you have cancelled permission in writing before then.

I understand that I may cancel this permission at any time by sending a letter to the health-care provider listed on Page 1.

I understand that, even if I cancel this permission, the health-care provider listed on Page 1 cannot take back any information that it shared with DTA and the Disability Evaluation Service when it had my permission to do so.

I also understand that my decision whether to give the health-care provider permission to share medical information with DTA and the Disability Evaluation Service is voluntary. However, I also understand that if I do not give permission to the health-care provider to share medical information with DTA and the Disability Evaluation Service, the decision about my disability will be made without consideration of this provider information.

_____ _____/_____/_____
Signature of applicant/recipient Date

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 equal 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 to12 months ❒ more than one year

4. ❒ has a physical and/or mental impairment(s) that does not meet or equal 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 to12 months ❒ more than one year

Your conclusions must be supported by objective clinical information.

PLEASE NOTE: If you have any questions regarding the disability criteria, please call 1-800-888-3420.

B. Examination Summary

1. Have you ever seen this patient before? ❒ yes ❒ no

2. Date of most recent examination ___/___/___ (must be within 30 days of date of report).

3. What is the disabling diagnosis/diagnoses? _____

_____

4. Date of onset of incapacitating condition ___/___/___

5. Expected duration of incapacitating condition _____

6. Is the patient's condition chronic and no improvement is expected? ❒ yes ❒ no If no, what is the month and year that improvement is expected?____/_____

7. Additional information/comments

_____

_____

8. Are any of the above conditions a result of an accident or injury? ❒ yes ❒ no If yes, explain _____

_____

_____

C. Standards

Check the standards that apply to this patient's impairment(s). You may reference the Department's Medical Standards at 106 CMR 320.200 or the SSI Listing of Impairments in the Code of Federal Regulations (CFR), Appendix 1 to Subpart P of Section 404, or at the following website: http://www.socialsecurity.gov

- ❒ Musculoskeletal System
- ❒ Special Senses & Speech
- ❒ Respiratory System
- ❒ Cardiovascular System
- ❒ Digestive System
- ❒ Genitourinary System
- ❒ Hemic & Lymphatic Systems
- ❒ Skin
- ❒ Endocrine System
- ❒ Multiple Body System
- ❒ Neurological System
- ❒ Mental Disorder
- ❒ Immuno-suppressive Disorder
- ❒ Neoplastic Diseases
- ❒ Medically Equivalent/ Combination of Impairments

If the SSI Listing of Impairments was referenced, please cite impairment(s)_____

_____

_____

_____

_____

_____

_____

_____

_____

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	Current Objective Clinical Findings	Treatment Plan
Primary Onset date ____/____/____ Date of Dx ____/____/____		
Secondary Onset date ____/____/____ Date of Dx ____/____/____		
Other Onset date ____/____/____ Date of Dx ____/____/____		

Patient's height _____ weight_____ blood pressure_____

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. Medication

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

Medication	Strength	Frequency	Side Effects

Part III - Physical Functioning

A. Based upon your medical evaluation of this patient, including consistently reported symptoms supported by objective medical findings, do you have a medical opinion regarding your patient's ability to perform the activities listed below in a work setting during a normal eight-hour workday? Your report should be the most that your patient can do despite his or her limitations or restrictions.

1. **Your patient's ability to stand and walk?**
Describe both capabilities and limitations in walking and standing (e.g. how far can your patient walk, how long can your patient stand?) _____

_____

2. **Your patient's ability to sit?**
Describe both capabilities and limitations in ability to sit (e.g. can your patient perform a job that primarily consists of sitting for an eight-hour workday with reasonable break periods?) _____

_____

3. **Your patient's ability to lift or carry?**
Describe both capabilities and limitations in ability to lift or carry (e.g. how much weight can your patient regularly lift or carry?)_____

_____

4. **Your patient's ability to stoop or bend?**
Describe both capabilities and limitations (e.g. does your patient's medical condition restrict him or her from stooping or bending?)_____

_____

5. **Other limitations?** (Fine manipulation, reaching, feeling/touch, vision, speech, environmental exposures, heights)
_____

_____

B. What activities of daily living (ADLs) is your patient able to perform independently? (e.g. dress, bathe, light house-work, laundry, driving, using public transit, shopping, work outside the home) _____

_____

C. What ADLs is your patient unable to perform independently? _____

_____

Part IV - Mental Functioning

A. Mental Status (recent observation):

1. Appearance/behavior _____
2. Perception (hallucinations) _____
3. Orientation (year, date, place, person, events) _____

_____

4. Thought content (phobias, obsessions, delusions, ideas of reference) _____

_____

5. Thought form (disassociation, blocking, few associations, flight of ideas) _____

_____

6. Cognitive Process (attention, immediate/recent memory) - Give specific examples:_____

_____

7. Prognosis (estimate of months until substantial improvement in function) _____

_____

8. Does your patient have low I.Q. or reduced intellectual function? ❒ yes ❒ no
   IQ test results or explanation _____

_____

B. Based upon your mental health evaluation of this patient, including consistently reported symptoms supported by objective psychiatric and psychological findings, do you have a clinical opinion regarding your patient's ability to perform the activities listed below in a work setting during a normal eight-hour workday? Your report should be the most that your patient can do despite his or her limitations or restrictions.

1. **Your patient's ability to understand and remember?**
   Describe both capabilities and limitations in understanding and remembering _____

_____

2. **Your patient's ability to concentrate and persist?**
   Describe both capabilities and limitations in concentration and persistence _____

_____

3. **Your patient's ability to interact with co-workers and supervisors?**
   Describe both capabilities and limitations in social interaction _____

_____

Part V - Physician's Signature

This Medical Report must be signed by a physician, osteopath 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 nurse practitioner who meets the educational and certification requirements mandated by state law and/or regulations.

_____ _____

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.