MARYLAND MEDICAL ASSISTANCE PROGRAM

PHYSICIAN REPORT

Date:_____

PART I. INSTITUTIONALIZED PERSON'S IDENTIFICATION
(To be completed by the Local Department of Social Services)

1. _____ _____
Name CID#

2. _____ _____
Name of Facility Telephone Number

_____
Address

3. _____ _____
Representative Name Telephone Number

_____
Address

4. _____ _____ _____
Case Manager Department of Social Services Telephone Number

_____
Address

PART II. STATEMENT BY ATTENDING PHYSICIAN

1. The anticipated length of stay in a Long Term Care Facility for the above named patient is:
(check the appropriate box)

☐ Remainder of Life *☐ Six Months or Less * ☐More Than Six Months

* (give expected month and year of discharge_____)

2. The medical reasons for this expectation are:

_____

_____

_____
(use back for additional space)

3. This person's ability to resume community (non-institutional) living requires the following support systems:

☐ Medical Day Care ☐ Home Health Care ☐ Personal Care

☐ Other_____ ☐ No support system(s) will be needed
Specify

I certify that I am the attending physician of the above name person and that the statements I have made concerning this person are based on my professional assessment of his/her medical condition and are supported by the person's medical record.

_____ _____ _____
Signature of Physician Printed Name of Physician Date

_____
Address

Notice to Medicaid Applicants

You are providing personal information (Name, Address, Date of Birth, Income History, Employment History, etc.) in this application for Medicaid benefits.

The purpose of requesting this personal information is to determine your eligibility for Medicaid. If you do not provide this personal information, the Medicaid Program may deny your application for benefits. You have a right to inspect, amend, or correct this personal information. The Medicaid Program will not permit inspection of your personal information, or make it available to others, except as permitted by federal and state law.