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| **PROGRAM INFORMATION** | STANDARD OF DAILY LIVING – APPLICATION PART 2 |
| STANDARD ASSESSMENT OF FUNCTIONAL CAPABILITY |
| The Maryland Department of Disabilities administers the Attendant Care Program. This program provides financial reimbursement to assist individuals with **severe chronic or permanent physical disabilities** who require attendant care services to direct their own care. To assist us, this Standard Assessment of Functional Capability form is used to determine if the applicant has a severe chronic or permanent physical disability that precludes or impairs the independent performance of essential activities of daily living. Please complete this Standard Assessment of Functional Capability form and return to:*Maryland Department of Disabilities**Attendant Care Program**217 East Redwood Street, Suite 1300**Baltimore, Maryland 21202* |
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| **APPLICANT/PATIENT INFORMATION** |

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| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | \_\_\_\_\_\_-\_\_\_\_\_\_-\_\_\_\_\_\_ |
| Name |  | Social Security No. |
| \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_\_\_ | \_\_\_\_\_\_\_ | (\_\_\_\_\_)\_\_\_\_\_-\_\_\_\_\_\_\_ |
| Date of Birth | Age | Telephone Number |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Street Address |  |  |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| City | State | Zip Code |

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| **PATIENT HEALTH EVALUATION** | Have you provided medical treatment to the above named applicant in the past? \_\_Yes \_\_NoDate of Initial Visit \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Most Recent Visit \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Medical History/Diagnosis** (A medical condition that substantially affects the applicant’s ability to perform physical activities such as walking, standing, transferring, seeing, or hearing.**Diagnosis:**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**Does above diagnosis affect applicant’s:** Yes No Yes Noability to walk ability to walk ability to transfer ability to see/hearability to stand ability to plan or make decision  |

I have examined the above named applicant and completed and Patient Health Evaluation section.

Attending Physician or R.N. Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_

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| ACTIVITIES OF DAILY LIVING |
| **MOBILITY** |  | No Assistance  | Some Assistance  | Full assistance  | **If assistance is needed, explain what kind of assistance is needed and how patient’s diagnosis affects their ability to perform the activity.** |
| Client Walks |  |  |  |  |
| Client Travels Beyond Walking Distance |  |  |  |  |
| Client Transfers to Bed or Chair |  |  |  |  |
|  |  |  |  |  |  |
| **PERSONAL CARE** | Client Completes Bathing |  |  |  |  |
| Client Completes Grooming |  |  |  |  |
| Client Gets Dressed/Changes Clothes |  |  |  |  |
| Client Uses Toilet |  |  |  |  |
|  |  |  |  |  |  |
| **EATING/HOUSKEEPING** | Client Eats |  |  |  |  |
| Client Prepares a Light Meal |  |  |  |  |
| Client Does Grocery Shopping |  |  |  |  |
| Client takes Medications |  |  |  |  |
| Client Does Light Chores |  |  |  |  |
|  |  |  |  |  |  |
| **OTHER** | Client Uses Telephone |  |  |  |  |
| Client Plans & Makes Decisions |  |  |  |  |
| Client Handles Own Money |  |  |  |  |
| Original Signature of Physician or R.N.:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

**This section to be completed by attending Physician on RN**

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| **Additional comments regarding onset of disability, diagnosis, prognosis and/or other limitations:** |
| \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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| **PHYSICIAN’S CERTIFICATION** |
| *I have examined this applicant and completed the Standard Assessment of Functional Capability form as required by Maryland Department of Disabilities. A copy of the physical exam is on record in my office and can be made available to the Attendant Care Program at the request of the applicant.*

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| Attending Physician or R.N. Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Date of Exam: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Print Physician / RN Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Office / Clinic Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Office Telephone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Office Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |
| Email Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |

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