MARYLAND DEPARTMENT OF HUMAN SERVICES
FAMILY INVESTMENT ADMINISTRATION
TCA SUPPLEMENTAL MEDICAL EVALUATION FORM – CHILD ONLY
(TO BE COMPLETED BY THE CHILD'S PARENT OR CARETAKER RELATIVE)

1. Child's Name: ______________________________ 2. DOB: ____________

3. Child's Disability: ______________________________

4. Is your child under the care of a doctor? ☐ YES ☐ NO

Doctor's Name: ______________________________

Address: ______________________ Telephone: ______________

City: __________________State: _______ Zip Code: ____________

5. Time you spend each day helping your child: ______________________________

6. List activities that your child cannot do without help: ______________________________

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7. List any other activities that your child cannot do without help: ______________________________

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8. Does your child attend school, Head Start, or day care? ☐ YES ☐ NO

If YES, check one (or more) of the following:
☐ Public/private school in grade______ ☐ Head Start ☐ Day Care

☐ Special Education – Intensity level: _____ Number of hours per day _________

9. Tell us why you are needed in the home to care for your child: ______________________________

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Customer's Signature: ______________________________ Date: ______________

Case Manager's Signature: ______________________________ Date: ______________

*Case Manager: If level IV or greater, refer to Maximus.