



**Massachusetts Department of Transitional Assistance
Emergency Aid to the Elderly, Disabled,
and Children (EAEDC)
Medical Provider Statement**

Give this form to DTA:

- Upload to DTA Connect
- Fax to 617-887-8765
- Mail to the DTA Document Processing Center: P.O. Box 4406, Taunton, MA 02780
- Scan at a local DTA office

Patient Name: _____ **Patient Date of Birth:** _____

Autorización del/de la paciente

Autorizo la divulgación de la información solicitada en este formulario al Departamento de Asistencia Transitoria. Autorizo también al Departamento a comunicarse con el proveedor médico únicamente a los fines de verificación.

Firma del/de la paciente

Fecha

Identificación de agencia del DTA

The patient named above has applied for, or is receiving assistance from, the Department of Transitional Assistance (DTA). They have stated that a disability or temporary health condition limits their ability to support themselves through work. They must verify this to get EAEDC cash assistance benefits (and in some cases, to get SNAP food benefits). This form requests information about that disability or health condition.

This form must be completed by a doctor, physician assistant, nurse practitioner, osteopath, psychiatrist, podiatrist, licensed clinical social worker, licensed mental health counselor or psychologist, or for pregnancy-related incapacity, a certified nurse midwife licensed by the Commonwealth of Massachusetts, who is familiar with the patient’s condition or who has conducted an exam within the last 30 days.

This patient has a health issue or combination of health issues that is expected to last 60 days or more and that substantially reduces or eliminates the patient’s ability to support their self.

Diagnosis	How long is condition expected to last?
	<input type="checkbox"/> 60 days to 12 months <input type="checkbox"/> More than 12 months or expected to result in death
	<input type="checkbox"/> 60 days to 12 months <input type="checkbox"/> More than 12 months or expected to result in death
	<input type="checkbox"/> 60 days to 12 months <input type="checkbox"/> More than 12 months or expected to result in death
	<input type="checkbox"/> 60 days to 12 months <input type="checkbox"/> More than 12 months or expected to result in death

I do not think this patient has or I do not have knowledge of this patient having a health issue or combination of health issues that is expected to last 60 days or more and that substantially reduces or eliminates the patient's ability to support their self.

Signature

Medical provider signature

Date

Medical provider name and title

Board of Registration Number

Address

Telephone number

This form can be provided to the patient for return to DTA or sent directly to DTA.