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:**_____

Patient Authorization

I authorize release of the information requested on this form to the Department of Transitional Assistance.
I also authorize the Department to contact the medical provider solely for verification purposes.

_____ _____
Patient signature Date

_____
DTA Agency ID

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?
	☐ 60 days to 12 months ☐ More than 12 months or expected to result in death
	☐ 60 days to 12 months ☐ More than 12 months or expected to result in death
	☐ 60 days to 12 months ☐ More than 12 months or expected to result in death
	☐ 60 days to 12 months ☐ 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.