Department of Transitional Assistance
Transitional Aid to Families with Dependent Children
Disability Supplement

Do you need help to fill out the attached form? Call DTA at 1-877-382-2363 right away. We can help you fill out the form.

You told DTA that you cannot work because of one or more health problems. UMASS/Disability Evaluation Services (DES) decides for DTA if you are disabled under the Transitional Aid to Families with Dependent Children program. DES will look at your medical records and other information to make this decision.

The attached form is called a "Disability Supplement". DES needs answers to the questions on this form to decide if you are disabled under DTA's rules. The form asks questions about your health problems and where you get treatment. The form also asks questions about your work history, your time in school, and what you do each day.

To get an exemption from the **TAFDC** work requirement and time limit based on your disability, you must:

- fill out the Disability Supplement and return it to: DTA Document Processing Center, P.O. Box 4406, Taunton MA 02780-0420, or fax to (617) 887-8765; and
- cooperate with DES.

If you do not do these things:

- **DTA may deny your application; or**
- **DTA may lower your benefits.**

Tell DTA right away if you need help to fill out the Disability Supplement.

Tell DTA right away if you need help to find a doctor.

(see other side) ▶

Department of Transitional Assistance
Transitional Aid to Families with Dependent Children
Disability Supplement

HOW TO FILL OUT THE DISABILITY SUPPLEMENT:

- **Sign and date a Medical Records Release Form for each medical and mental health provider listed on page 3, Part 2: Information about all Your Medical and Mental Health Providers. Medical and mental health providers may include doctors, nurses, psychologists, psychiatrists, therapists, nurse practitioners, physical therapists, social workers, chiropractors, hospitals, health centers, or clinics from whom you receive treatment. It is very important that you sign and date a different form for each provider. DES will return the forms to you if you do not sign and date a different form for each provider.**

- Type or print clearly.

- Use a pen. Do not use a pencil.

- Fill out the form the best you can. Call DTA if you have questions or need help to fill out the form. You can also call the DES Help Line at 1-888-497-9890 for help filling out this form.
- Write down details about every medical **and** mental health problem you have.

- Mail the completed original form to: DTA Document Processing Center, P.O. Box 4406, Taunton MA 02780-0420, or fax to (617) 887-8765.

DTA will send the form to DES. DES will review the form. DES will ask for medical records from all of the doctors and other health care providers that you list on the form. DES will call you or send you a letter if it needs more information.

DES will decide your case faster if you fill out every part of the form. DES will decide your case faster if you sign and date a separate Medical Records Release Form for **each** medical and mental health provider.

Client Name_____ Agency ID_____

Disability Supplement

Tell DTA if you need help with this form. You can also call the UMASS/Disability Evaluation Services (DES) Help Line at 1-888-497-9890.

Information about you

Last Name	First Name	Middle Initial	Social Security Number - -
Street Address Apartment Number/Suite			☐ Male ☐ Female
City/Town	ZIP Code		Date of Birth / /
Home Telephone Number	Cell Phone Number	Work/Other Phone Number	
Case Name (if different)	Case Social Security Number (if different)		

Fill out every section of this form. If you do not fill out every section, we may not be able to decide if you are disabled.

We may need to schedule a doctor's appointment for you. What are the best times for you to go to an appointment? Please check all the times that are best for you.

☐ Any time is ok				
☐ Monday A.M. ☐ Monday P.M.	☐ Tuesday A.M. ☐ Tuesday P.M.	☐ Wednesday A.M. ☐ Wednesday P.M.	☐ Thursday A.M. ☐ Thursday P.M.	☐ Friday A.M. ☐ Friday P.M.

Did you apply for Social Security or SSI/SSDI benefits? ☐ Yes ☐ No

If yes, did you see a doctor for an exam? Doctor's Name:

Date of exam: _____/_____/_____

Have you ever experienced domestic violence? ☐ Yes ☐ No

If yes, are you working with a domestic violence specialist? ☐ Yes ☐ No

Please tell us the person's name and phone number:

Client Name_____ Agency ID_____

Disability Supplement

Part 1. Your Health Problems

List and describe all your medical and mental health problems. Write down everything that makes it hard for you to work. Write down details about a problem even if you do not get treatment or take medicine for the problem.

List your medical and/or mental health problems.	Describe the symptoms or pain related to each health problem.	Date when problem started.	Medications
Depression **EXAMPLE**	*Very tired all the time. Hard to get out of bed in the morning. I cry a lot during the day. I can't control when I cry.*	*April 2007*	*None*
Back pain **EXAMPLE**	*Pain starts in my lower back and goes down my leg*	*June 2002*	*Skelexin*

Did any of your health problems start because of an accident or injury? ☐ Yes ☐ No
If yes, please explain:

Disability Supplement

Part 2. Information about all your Medical and Mental Health Providers

Did you get any health care in the past year? ☐ Yes ☐ No

Please list every doctor, nurse, psychologist, psychiatrist, therapist, nurse practitioner, physical therapist, social worker, chiropractor, hospital, health center, or clinic that treated you for any of your health problems since they started. If you cannot remember them all, do the best you can. You can write on a separate piece of paper if you run out of space.

Name of Doctor, Nurse, Psychologist, Psychiatrist, Therapist, Nurse Practitioner, Physical Therapist, Social Worker, Chiropractor, Hospital, Health Center, or Clinic	Reason for Visit	Was this visit in the past year?
		☐ **Yes** ☐ **No**
		☐ **Yes** ☐ **No**
		☐ **Yes** ☐ **No**
		☐ **Yes** ☐ **No**
		☐ **Yes** ☐ **No**
		☐ **Yes** ☐ **No**
		☐ **Yes** ☐ **No**
		☐ **Yes** ☐ **No**

Please fill out a Medical Records Release Form for each doctor, nurse, psychologist, psychiatrist, therapist, nurse practitioner, physical therapist, social worker, chiropractor, hospital, health center, or clinic on this list. Be sure to sign and date each form.

These Medical Records Release Forms are at the end of this form.

Part 3. Where You Live

Where do you live? (Check one.)

☐ House or apartment	☐ Homeless	☐ Group Home	☐ State Facility
☐ Nursing Home	☐ Rehabilitation Hospital		☐ Other (describe)

Disability Supplement

Part 4. What You Can Do

Are you:

☐ Right Handed? ☐ Left Handed?

Do your medical or mental health problems **make it hard for you** to do any of the following things?		
	If Yes, check here	If yes, please explain:
Dress and bathe **EXAMPLE**	✓	*My shoulder pain makes it hard for me to lift my arm over my head. This makes it hard to put on shirts or wash my hair.*
Do regular housework **EXAMPLE**	✓	*When I am depressed, I don't care if my house is clean.*
Sit	☐	
Stand	☐	
Walk	☐	
Bend	☐	
Reach	☐	
Lift	☐	
Remember	☐	
See	☐	
Hear	☐	
Use your hands	☐	
Dress and bathe	☐	
Do regular housework	☐	
Listen to music	☐	
Watch TV	☐	
Use a computer	☐	
Read	☐	
Talk on the phone	☐	
Arts and Crafts	☐	
Go outside	☐	
Go for a walk	☐	
Get from one place to another	☐	
Go shopping	☐	
Go to the doctor	☐	
Visit friends and family	☐	

Disability Supplement

Part 4. What You Can Do (continued)

Do your medical or mental health problems **make it hard for you** to do any of the following things?		
	If Yes, check here	If yes, please explain:
Go out to eat	☐	
Go to school	☐	
Handle money	☐	
Use an ATM	☐	
Drive a car	☐	
Take a bus or train	☐	
Play sports	☐	
Other (describe)	☐	

Part 5. Your Language

Do you speak English?	☐Yes ☐No ☐Limited
Do you understand English?	☐Yes ☐No ☐Limited
Do you read English?	☐Yes ☐No ☐Limited
Do you write English?	☐Yes ☐No ☐Limited
What is your first language?	
Can you read in your first language?	☐Yes ☐No ☐Limited
Can you write in your first language?	☐Yes ☐No ☐Limited

Part 6. School

1. Check the highest grade of school you finished.									
☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8	
☐ 9	☐ 10	☐ 11	☐ 12	☐ GED	☐ 13	☐ 14	☐ 15	☐ 16	☐ 17+

What year did you finish this grade?	
Where did you go to school?	
Did you repeat any grades?	☐Yes ☐No
Were you in special education?	☐Yes ☐No ☐ Not sure
Did you finish more than 12 years of school?	☐Yes ☐No
If yes, please list your degree and major:	

Disability Supplement

Did you get any other training?	☐ Yes ☐ No
If yes, please fill out the sections below.	

Type of Training	Year	Finished	Certified/Licensed?
Building Trades		☐ Yes ☐ No	☐ Yes ☐ No
Electronics		☐ Yes ☐ No	☐ Yes ☐ No
Cooking		☐ Yes ☐ No	☐ Yes ☐ No
Auto Mechanic		☐ Yes ☐ No	☐ Yes ☐ No
Computers		☐ Yes ☐ No	☐ Yes ☐ No
Hairdressing		☐ Yes ☐ No	☐ Yes ☐ No
Cosmetology		☐ Yes ☐ No	☐ Yes ☐ No
Nurse's Aide		☐ Yes ☐ No	☐ Yes ☐ No
Secretarial		☐ Yes ☐ No	☐ Yes ☐ No
Other (describe)		☐ Yes ☐ No	☐ Yes ☐ No

Part 7. Your Work

Do you work now?	☐ Yes ☐ No
If no, when did you stop working?	Date:___/___/___

Did any of your medical or mental health conditions cause problems at work?	☐ Yes ☐ No
If yes, explain:	

Client Name_____ Agency ID_____

Disability Supplement

List all your jobs from the last 15 years. Do the best that you can. If you do not know the exact dates, write your best guess. Start with the job you have now or your last job. Add a piece of paper if you need more space. You can attach a resume if you have one. To help you complete this part we included an example below. **Example**:

Job Title	**Dates Worked**	
Packer	From (Month/Year): *March 2004*	To (Month/Year): *May 2005*
Job Duties (List everything you did):		
Put three golf balls into a small box. Packed 24 small boxes into a case. Sealed the case with packing tape. Loaded cases onto a platform.		
How many hours did you work each week? *40*	**How much did you make an hour?** *$9.00/hour*	**Reason for leaving:** *Moved*

Job Title	**Dates Worked**	
	From (Month/Year):	To (Month/Year):
Job Duties (List everything you did):		
How many hours did you work each week?	**How much did you make an hour?**	**Reason for leaving:**

Job Title	**Dates Worked**	
	From (Month/Year):	To (Month/Year):
Job Duties (List everything you did):		
How many hours did you work each week?	**How much did you make an hour?**	**Reason for leaving:**

Disability Supplement

Job Title	Dates Worked	
	From (Month/Year):	To (Month/Year):
Job Duties (List everything you did):		
How many hours did you work each week?	**How much did you make an hour?**	**Reason for leaving:**

Job Title	Dates Worked	
	From (Month/Year):	To (Month/Year):
Job Duties (List everything you did):		
How many hours did you work each week?	**How much did you make an hour?**	**Reason for leaving:**

Job Title	Dates Worked	
	From (Month/Year):	To (Month/Year):
Job Duties (List everything you did):		
How many hours did you work each week?	**How much did you make an hour?**	**Reason for leaving:**

Client Name_____ Agency ID_____

Disability Supplement

Check each of the things you do in your job. If you do not work, check each thing you did in your last job.			
☐ Doing paperwork	☐ Using a computer	☐ Assembling	☐ Operating machines
☐ Filing	☐ Serving people	☐ Counting & packing	☐ Construction
☐ Using phone	☐ Driving a car or truck	☐ Moving things	☐ Cleaning
☐ Using office machines	☐ Using cash register	☐ Driving forklift	☐ Using power tools
☐ Other (please describe)		☐ Using hand tools	

Circle the number of hours you do each thing in your job. If you do not work, circle the number of hours you did each thing in your last job.									
Activity	**Hours in a Day**								
Walk or stand	0	1	2	3	4	5	6	7	8
Sit	0	1	2	3	4	5	6	7	8
Reach	0	1	2	3	4	5	6	7	8

Check the weight you lift or carry most:	Check the heaviest weight you lift:
☐ Less than 10 lbs.	☐ Less than 10 lbs.
☐ 10 lbs.	☐ 10 lbs.
☐ 20 lbs.	☐ 20 lbs.
☐ 25 lbs.	☐ 25 lbs.
☐ 50 lbs.	☐ 50 lbs.
☐ 100 lbs.	☐ 100 lbs.
☐ More than 100 lbs.	☐ More than 100 lbs.

Part 8. Your Comments

Use this space to write more information needed, including information about why you cannot work.

Disability Supplement

Part 9. Help with This Form

Did you need help to fill out this form?	☐ Yes ☐ No
If yes, why did you need help?	

Part 10. Your Signature

THIS SECTION MUST BE COMPLETED.	
_____ **Signature of Applicant/Client/Guardian**	_____ **Date**

If this form is being filled out by someone with the legal authority to act on behalf of the applicant/client or a legal guardian, give us the following information:

Signature of person filling out this form:_____

Print name: _____

Authority of person filling out this form on behalf of the applicant/client: _____

Part 11. Your Permission to Share Information

Do you give permission to share information about this application with anyone besides your health care providers? (For example: relative, friend, legal representative.) DES may send copies of notices to this person. This does **not** authorize release of medical records.	☐ Yes ☐ No

If yes, person's name: Relationship to you:

Address: Phone number(s):

_____ _____

Signature of Applicant or Client **Date**

For Office Use Only
DTA Comments and Signature

_____

_____

_____

_____ _____

Authorized Signature **Date**