Give this form to DTA:

* By mail: DTA Document Processing Center,
P.O. Box 4406, Taunton MA 02780-0420
* By fax: (617) 887-8765
* In person at your local DTA office

***Massachusetts Department of Transitional Assistance***

**Good Cause** **Medical Statement**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Client name Agency ID or last 4 of SSN

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient name (if different) Patient date of birth

**For the patient:** You asked for a disability exemption from the TAFDC time limit and work requirement. Because DTA’s Disability Evaluation Service (DES) denied your disability claim before, you will not be exempt unless DES decides you are disabled. However, if a medical provider completes this form, the TAFDC work requirement will not affect you while DES is making a decision.

**Patient Authorization**

I authorize release of the information requested on this form to the Department of Transitional Assistance.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Patient signature Date

**For the Medical Provider:** Please complete the form below and return to the patient or send directly to DTA. A doctor, nurse practitioner, osteopath, or psychologist licensed in Massachusetts may sign this form.

**Medical Information**

|  |  |  |  |
| --- | --- | --- | --- |
| Diagnosis | Onset date (if known) | Date of diagnosis | How long is condition expected to last? |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

Date of most recent medical exam: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever examined or treated this patient before? \_\_\_\_ Yes \_\_\_\_ No If yes, when?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are any of the conditions listed above the result of an accident? \_\_\_\_ Yes \_\_\_\_ No

**Impact on Work Activities**

**Good Cause Medical Statement**

Does a physical or mental condition or cognitive impairment prevent this patient from consistently meeting the TAFDC work program requirement of \_\_\_\_ hours each week? (To meet this requirement, clients may do paid work, volunteer work, attend school or a training program, or do job search.) \_\_\_\_ Yes \_\_\_\_ No

If yes, please explain why the patient cannot do the required hours of work activities:\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How many hours each week can this patient consistently work or participate in an activity? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If the patient can work some hours, list any restrictions on activities: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Signature**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medical provider signature Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Medical provider name and title

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Board of Registration Number

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address Telephone number

This institution is an equal opportunity provider.

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