Massachusetts Department of Transitional Assistance

SNAP Caring for a Person with a Disability Form

Date:

_____
Caregiver's Name

_____ _____
Head of Household Name (if different) Head of Household Agency ID

To Medical Provider: This caregiver states that they are required to provide care for

_____ _____
Name of Patient D.O.B. of Patient

Does this patient's condition require the caregiver to provide consistent care? ☐ Yes ☐ No

If the patient attends school full-time or is out of the home during the day (i.e. adult day care), does the patient require care during the remainder of day and/or night which prevents the caregiver from seeking, getting or maintaining work of at least 20 hours per week? ☐ Yes ☐ No

_____ _____
Medical Provider Signature* Print Medical Provider Name Date

_____ ( )_____
Name of Institution Address Telephone Number

* A physician, physician's assistant, nurse practitioner, osteopath, psychologist or licensed mental health counselor. Give the completed form back to DTA.

Please send the completed form to DTA or return it to the caregiver.

This institution is an equal opportunity provider.

We must not discriminate due to race, color, national origin, sex (including gender identity and sexual orientation), disability, age, or reprisal or retaliation for prior civil rights activity. If you think that we have discriminated against you, call 617-348-8555 to find out how to file a complaint.