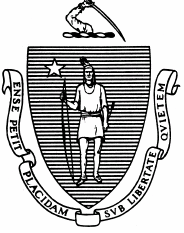
***Massachusetts Department of Transitional Assistance***



**SNAP Disability Verification for Elderly Noncitizens**

**Section I: Medical Release**

By signing below I authorize release of the medical information in Section II of this form to the Department of Transitional Assistance.

Applicant’s Printed Name Applicant’s Signature Social Security Number

Address City/Town ZIP

**Section II: Medical Practitioner’s Statement**

To qualify for Supplemental Nutrition Assistance Program (SNAP) benefits, the individual named above needs to verify that she or he has a disability.

For this purpose, disability is defined as (1) having a severe physical or mental impairment, (2) that has lasted or is expected to last for 12 months or result in death, and (3) that makes the person unable to engage in past work or in any other substantial work in light of the person’s age, education, and work experience.

Disability must be verified by a licensed medical practitioner.

We appreciate your completing this form. **All parts *must* be completed.**

Diagnoses:

1. Is/are the impairment(s) severe (more than slight)?  **Yes  No**

2. Will the impairment(s) last 12 months or result in death?  **Yes  No**

3. Is this person unable to perform substantial gainful employment on a sustained basis in light of the individual’s physical and/or mental impairment(s), age, education, language barriers and work experience?  **Yes  No**

If this person cannot perform substantial gainful employment, explain (*must* be completed):

I certify that I am a licensed medical practitioner, that I have examined the above individual, and that the information provided is true and accurate.

Name (please print)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Title\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Telephone Number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

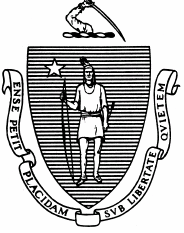
Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SNAP-DVEN (9/2017)

09-120-0917-05

This institution is an equal opportunity provider.

***Departamento de Asistencia Transicional de Massachusetts***



**Verificación de discapacidad para personas mayores no ciudadanos que solicitan Beneficios de SNAP**

**Sección I: Autorización del historial médico**

Al firmar abajo, autorizo la entrega del historial médico ubicado en la Sección II de este formulario al Departamento de Asistencia Transicional.

Nombre del Solicitante (en letra de imprenta) Firma del Solicitante Número Seguro Social (SSN)

Dirección Ciudad/Pueblo Código Postal

**Section II: Medical Practitioner’s Statement**

To qualify for food stamps, the individual named above needs to verify that she or he has a disability.

For this purpose, disability is defined as (1) having a severe physical or mental impairment, (2) that has lasted or is expected to last for 12 months or result in death, and (3) that makes the person unable to engage in past work or in any other substantial work in light of the person’s age, education, and work experience.

Disability must be verified by a licensed medical practitioner.

We appreciate your completing this form. **All parts *must* be completed.**

Diagnoses:

1. Is/are the impairment(s) severe (more than slight)?  **Yes  No**

2. Will the impairment(s) last 12 months or result in death?  **Yes  No**

3. Is this person unable to perform substantial gainful employment on a sustained basis in light of the individual’s physical and/or mental impairment(s), age, education, language barriers and work experience?  **Yes  No**

If this person cannot perform substantial gainful employment, explain (*must* be completed):

I certify that I am a licensed medical practitioner, that I have examined the above individual, and that the information provided is true and accurate.

Name (please print)\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Title\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Telephone Number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Esta institución es un proveedor que ofrece igualdad de oportunidades.

SNAP-DVEN(S) (9/2017)

09-120-0917-05