**Instructions**

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.

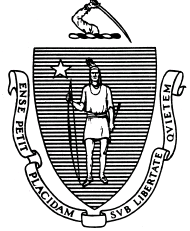
**To the Client:**

Use this form to tell us if you are caring for a disabled person who lives with you. If you cannot look for or keep a full-time job because you are caring for this person, you will be exempt from the TAFDC time limit and work rules.

A doctor, nurse practitioner, osteopath or psychologist may complete this form. Give the completed form back to DTA.

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**Verification of Caring for the Disabled**

***Massachusetts Department of Transitional Assistance***

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

Caregiver’s Name

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_   
Head of Household Name (if different) Head of Household Agency ID or last 4 of SSN

**To Medical Provider**: This caregiver states that s/he is required to provide care for

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.

Name of Patient D.O.B. of Patient

Does this patient’s condition require the caregiver to provide essential care?  Yes  No

Describe the condition, its severity, and the extent of care the patient requires:

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

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**If the patient is a child**: Does the child attend school full time?  Yes  No

Is the child otherwise out of the home?  Yes. Where?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  No

If the child attends school full time or is out of the home, does the child have disability-related needs during the day and/or night which prevent the caregiver from seeking, getting or maintaining full-time work?  Yes  No Explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**If the patient is an adult:** Does the patient have disability-related needs which prevent the caregiver from seeking, getting or maintaining full-time work?  Yes  No Explain:

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Medical Provider Signature\* Print Medical Provider Name Date

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ ( )\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address Telephone Number

\*A doctor, nurse practitioner, osteopath, or psychologist may sign.

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