**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

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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.