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

<table>
<thead>
<tr>
<th>Diagnosis</th>
<th>Onset date (if known)</th>
<th>Date of diagnosis</th>
<th>How long is condition expected to last?</th>
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</table>
Good Cause Medical Statement

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

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.