Instructions

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.

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.
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:

________________________________________________________________________________________________
________________________________________________________________________________________________
________________________________________________________________________________________________

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: ____________________________________________________________

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:

________________________________________________________________________________________________
________________________________________________________________________________________________

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.