APPENDIX B

EAEDC DISABILITY SUPPLEMENT

This DTA document is also available for downloading in both English and Spanish. You can access it on www.MassLegalServices.org in the Benefits Category.

Department of Transitional Assistance
Emergency Aid to the Elderly, Disabled and Children
Disability Supplement

Do you need help to fill out the attached form? Call DTA at 1-877-382-2363. DTA can help you fill out the form.

You told DTA that you cannot work because of one or more health problems. UMASS/Disability Evaluation Services (DES) decides for DTA if you are disabled under the Emergency Aid to the Elderly, Disabled and Children (EAEDC) program. DES will look at your medical records and other information to make this decision.

The attached form is called a "Disability Supplement." DES needs answers to the questions on this form to decide if you are disabled under DTA's rules. The form asks questions about your health problems and where you get treatment. The form also asks questions about your work history, your time in school, and what you do each day.

To get **EAEDC** based on your disability, you must:

- fill out the Disability Supplement and mail it to: DTA, P.O. Box 4406, Taunton, MA 02780-0420, or Fax to 617-887-8765;
- submit an EAEDC Medical Report; and
- cooperate with DES.

If you do not do these things DTA may deny or close your case.

Tell DTA right away if you need help to fill out the Disability Supplement.

Tell DTA right away if you need help to find a doctor.

(see other side) ▶

Department of Transitional Assistance
Emergency Aid to the Elderly, Disabled and Children
Disability Supplement

HOW TO FILL OUT THE DISABILITY SUPPLEMENT:

- **Sign and date a Medical Records Release Form for each medical and mental health provider listed on page 3, Part 2: Information about all Your Medical and Mental Health Providers. Medical and mental health providers may include doctors, nurses, psychologists, psychiatrists, therapists, nurse practitioners, physical therapists, social workers, chiropractors, hospitals, health centers, or clinics from whom you receive treatment. It is very important that you sign and date a different form for each provider. DES will return the forms to you if you do not sign and date a different form for each provider.**

- Type or print clearly.

- Use a pen. Do not use a pencil.

- Fill out the form the best you can. Call DTA if you have questions or need help to fill out the form. You can also call the DES Help Line at 1-888-497-9890 for help filling out this form.

- Write down details about every medical **and** mental health problem you have.

- Mail the completed original form to: DTA, P.O. Box 4406, Taunton, MA 02780-0420.

DTA will send the Disability Supplement and the EAEDC Medical Report to DES. DES will review the forms. DES will ask for medical records from all of the doctors and other health care providers that you list on the form. DES will call you or send you a letter if it needs more information.

DES will decide your case faster if you fill out every part of the Disability Supplement. DES will decide your case faster if you sign and date a separate Medical Records Release Form for **each** medical and mental health provider.

Disability Supplement

Tell DTA if you need help with this form. You can also call the UMASS/Disability Evaluation Services (DES) Help Line at 1-888-497-9890.

Information about you

Last Name	First Name	Middle Initial	Social Security Number
Street Address	Apartment Number/Suite		☐ Male ☐ Female
City/Town	ZIP Code		Date of Birth ____/____/____
Home Telephone Number	Cell Phone Number	Work/Other Phone Number	

Case Name (if different)	Case Social Security Number (if different)

Fill out every section of this form. If you do not fill out every section, we may not be able to decide if you are disabled.

We may need to schedule a doctor's appointment for you. What are the best times for you to go to an appointment? Please check all the times that are best for you.

☐ Any time is ok				
☐ Monday A.M. ☐ Monday P.M.	☐ Tuesday A.M. ☐ Tuesday P.M.	☐ Wednesday A.M. ☐ Wednesday P.M.	☐ Thursday A.M. ☐ Thursday P.M.	☐ Friday A.M. ☐ Friday P.M.

Did you apply for Social Security or SSI/SSDI benefits? ☐ Yes ☐ No

If yes, did you see a doctor for an exam? Doctor's Name:

Date of exam: _____/_____/_____

Have you ever experienced domestic violence? ☐ Yes ☐ No

If yes, are you working with a domestic violence specialist? ☐ Yes ☐ No

Please tell us the person's name and phone number:

Disability Supplement

Part 1. Your Health Problems

List and describe all your medical and mental health problems. Write down everything that makes it hard for you to work. Write down details about a problem even if you do not get treatment or take medicine for the problem.

List your medical and/or mental health problems.	Describe the symptoms or pain related to each health problem.	Date when problem started.	Medications
Depression **EXAMPLE**	*Very tired all the time. Hard to get out of bed in the morning. I cry a lot during the day. I can't control when I cry.*	*April 2007*	*None*
Back pain **EXAMPLE**	*Pain starts in my lower back and goes down my leg*	*June 2002*	*Skelexin*
	○		

Did any of your health problems start because of an accident or injury? ☐ Yes ☐ No
If yes, please explain:

Disability Supplement

Part 2. Information about all your Medical and Mental Health Providers

Did you get any health care in the past year? ☐ Yes ☐ No

Please list every doctor, nurse, psychologist, psychiatrist, therapist, nurse practitioner, physical therapist, social worker, chiropractor, hospital, health center, or clinic that treated you for any of your health problems since they started. If you cannot remember them all, do the best you can. You can write on a separate piece of paper if you run out of space.

Name of Doctor, Nurse, Psychologist, Therapist, Nurse Practitioner, Physical Therapist, Social Worker, Chiropractor, Hospital, Health Center, or Clinic	Reason for Visit	Was this visit in the past year?
		☐ **Yes** ☐ **No**
		☐ **Yes** ☐ **No**
		☐ **Yes** ☐ **No**
		☐ **Yes** ☐ **No**
		☐ **Yes** ☐ **No**
		☐ **Yes** ☐ **No**
		☐ **Yes** ☐ **No**
		☐ **Yes** ☐ **No**

Please fill out a Medical Records Release Form for each doctor, nurse, psychologist, psychiatrist, therapist, nurse practitioner, physical therapist, social worker, chiropractor, hospital, health center, or clinic on this list. Be sure to sign and date each form.

These Medical Records Release Forms are at the end of this form.

Part 3. Where You Live

Where do you live? (Check one.)			
☐ House or apartment	☐ Homeless	☐ Group Home	☐ State Facility
☐ Nursing Home	☐ Rehabilitation Hospital		☐ Other (describe)

Disability Supplement

Part 4. What You Can Do

Are you:

☐ Right Handed? ☐ Left Handed?

Do your medical or mental health problems **make it hard for you** to do any of the following things?		
	If Yes, check here	If yes, please explain:
Dress and bathe **EXAMPLE**	✓	*My shoulder pain makes it hard for me to lift my arm over my head. This makes it hard to put on shirts or wash my hair.*
Do regular housework **EXAMPLE**	✓	*When I am depressed, I don't care if my house is clean.*
Sit	☐	
Stand	☐	
Walk	☐	
Bend	☐	
Reach	☐	
Lift	☐	
Remember	☐	
See	☐	
Hear	☐	
Use your hands	☐	
Dress and bathe	☐	
Do regular housework	☐	
Listen to music	☐	
Watch TV	☐	
Use a computer	☐	
Read	☐	
Talk on the phone	☐	
Arts and Crafts	☐	
Go outside	☐	
Go for a walk	☐	
Get from one place to another	☐	
Go shopping	☐	
Go to the doctor	☐	
Visit friends and family	☐	

Disability Supplement

Part 4. What You Can Do (continued)

Do your medical or mental health problems **make it hard for you** to do any of the following things?		
	If Yes, check here	If yes, please explain:
Go out to eat	☐	
Go to school	☐	
Handle money	☐	
Use an ATM	☐	
Drive a car	☐	
Take a bus or train	☐	
Play sports	☐	
Other (describe)	☐	

Part 5. Your Language

Do you speak English?	☐Yes ☐No ☐Limited
Do you understand English?	☐Yes ☐No ☐Limited
Do you read English?	☐Yes ☐No ☐Limited
Do you write English?	☐Yes ☐No ☐Limited
What is your first language?	
Can you read in your first language?	☐Yes ☐No ☐Limited
Can you write in your first language?	☐Yes ☐No ☐Limited

Part 6. School

1. Check the highest grade of school you finished.									
☐ 0	☐ 1	☐ 2	☐ 3	☐ 4	☐ 5	☐ 6	☐ 7	☐ 8	
☐ 9	☐ 10	☐ 11	☐ 12	☐ GED	☐ 13	☐ 14	☐ 15	☐ 16	☐ 17+

What year did you finish this grade?	
Where did you go to school?	
Did you repeat any grades?	☐Yes ☐No
Were you in special education?	☐Yes ☐No ☐ Not sure
Did you finish more than 12 years of school?	☐Yes ☐No
If yes, please list your degree and major:	

Disability Supplement

Did you get any other training?	Yes	No
If yes, please fill out the sections below.		

Type of Training	Year	Finished	Certified/Licensed?
Building Trades		☐ Yes ☐ No	☐ Yes ☐ No
Electronics		☐ Yes ☐ No	☐ Yes ☐ No
Cooking		☐ Yes ☐ No	☐ Yes ☐ No
Auto Mechanic		☐ Yes ☐ No	☐ Yes ☐ No
Computers		☐ Yes ☐ No	☐ Yes ☐ No
Hairdressing		☐ Yes ☐ No	☐ Yes ☐ No
Cosmetology		☐ Yes ☐ No	☐ Yes ☐ No
Nurse's Aide		☐ Yes ☐ No	☐ Yes ☐ No
Secretarial		☐ Yes ☐ No	☐ Yes ☐ No
Other (describe)		☐ Yes ☐ No	☐ Yes ☐ No

Part 7. Your Work

Do you work now?	☐ Yes ☐ No
If no, when did you stop working?	Date:

Did any of your medical or mental health conditions cause problems at work?	☐ Yes ☐ No
If yes, explain:	

Client Name_____ Agency ID_____

Disability Supplement

List all your jobs from the last 15 years. Do the best that you can. If you do not know the exact dates, write your best guess. Start with the job you have now or your last job. Add a piece of paper if you need more space. You can attach a resume if you have one. To help you complete this part we included an example below.

Example:

Job Title	**Dates Worked**	
Packer	From (Month/Year): *March 2004*	To (Month/Year): *May 2005*
Job Duties (List everything you did):		
Put three golf balls into a small box. Packed 24 small boxes into a case. Sealed the case with packing tape. Loaded cases onto a platform.		
How many hours did you work each week? *40*	**How much did you make an hour?** *$9.00/hour*	**Reason for leaving:** *Moved*

Job Title	**Dates Worked**	
	From (Month/Year):	To (Month/Year):
Job Duties (List everything you did):		
How many hours did you work each week?	**How much did you make an hour?**	**Reason for leaving:**

Job Title	**Dates Worked**	
	From (Month/Year):	To (Month/Year):
Job Duties (List everything you did):		
How many hours did you work each week?	**How much did you make an hour?**	**Reason for leaving:**

Client Name_____ Agency ID_____

Disability Supplement

Job Title	Dates Worked	
	From (Month/Year):	To (Month/Year):
Job Duties (List everything you did):		
How many hours did you work each week?	**How much did you make an hour?**	**Reason for leaving:**

Job Title	Dates Worked	
	From (Month/Year:	To (Month/Year):
Job Duties (List everything you did):		
How many hours did you work per week?	**How much did you make per hour?**	**Reason for leaving:**

Job Title	Dates Worked	
	From (Month/Year):	To (Month/Year):
Job Duties (List everything you did):		
How many hours did you work each week?	**How much did you make an hour?**	**Reason for leaving:**

Disability Supplement

Check each of the things you do in your job. If you do not work, check each thing you did in your last job.			
☐ Doing paperwork	☐ Using a computer	☐ Assembling	☐ Operating machines
☐ Filing	☐ Serving people	☐ Counting & packing	☐ Construction
☐ Using phone	☐ Driving a car or truck	☐ Moving things	☐ Cleaning
☐ Using office machines	☐ Using cash register	☐ Driving forklift	☐ Using power tools
☐ Other (please describe)		☐ Using hand tools	

Circle the number of hours you do each thing in your job. If you do not work, circle the number of hours you did each thing in your last job.

Activity	**Hours in a Day**								
Walk or stand	0	1	2	3	4	5	6	7	8
Sit	0	1	2	3	4	5	6	7	8
Reach	0	1	2	3	4	5	6	7	8

Check the weight you lift or carry most:	Check the heaviest weight you lift:
☐ Less than 10 lbs.	☐ Less than 10 lbs.
☐ 10 lbs.	☐ 10 lbs.
☐ 20 lbs.	☐ 20 lbs.
☐ 25 lbs.	☐ 25 lbs.
☐ 50 lbs.	☐ 50 lbs.
☐ 100 lbs.	☐ 100 lbs.
☐ More than 100 lbs.	☐ More than 100 lbs.

Part 8. Your Comments

Use this space to write more information needed, including information about why you cannot work.

Disability Supplement

Part 9. Help with This Form

Did you need help to fill out this form?	☐ Yes ☐ No
If yes, why did you need help?	

Part 10. Your Signature

THIS SECTION MUST BE COMPLETED.	
_____	_____
Signature of Applicant/Client/Guardian	**Date**

If this form is being filled out by someone with the legal authority to act on behalf of the applicant/client or a legal guardian, give us the following information:

Signature of person filling out this form:_____

Print name: _____

Authority of person filling out this form on behalf of the applicant/client: _____

Part 11. Your Permission to Share Information

Do you give permission to share information about this application with anyone besides your health care providers? (For example: relative, friend, legal representative.) DES may send copies of notices to this person. This does **not** authorize release of medical records.	☐ Yes ☐ No

If yes, person's name: _____ Relationship to you: _____

Address: _____ Phone number(s): _____

_____ _____

Signature of Applicant or Client **Date**

For Office Use Only
DTA Comments and Signature

_____

_____

_____

_____ _____

Authorized Signature **Date**

Department of Transitional Assistance (DTA) and Disability Evaluation Services (DES) Medical Records Release Form

Sign this form to let your medical or mental health care provider share information with UMASS/Disability Evaluation Services (DES).

HOW TO FILL OUT THIS FORM

Your medical or mental health care provider will only send medical records to UMASS/Disability Evaluation Services if you fill out the form right. Follow these steps:

1. **Fill out a separate Medical Records Release Form for each medical or mental health care provider. A medical provider is a doctor, nurse, nurse practitioner, physical therapist, social worker, chiropractor, hospital, health center or clinic from whom you receive treatment. A mental health care provider is a psychologist, psychiatrist or therapist.**
2. **Fill out every section of the form. DES can only get your medical information if you fill out every section. DES will decide your case without the information if DES cannot get it.**
3. **Sign and date the form with a pen. Do not sign with a pencil. Sign the form yourself. You cannot use a copy or stamp of your signature**.

SECTION I

Your Name and Address

Print name of applicant/client:	Telephone Number: (	
Street address:		Date of birth:
City/Town	State:	ZIP:

SECTION II

Health Care Provider's Name and Address

Name of doctor, nurse, psychologist, psychiatrist, therapist, nurse practitioner, physical therapist, social worker, chiropractor, hospital, health center or clinic from whom you receive treatment:		
Street address:		
City/Town	State:	ZIP:
Telephone Number: (		

(continued on back) ▶

SECTION III

I allow the medical or mental health care provider listed in Section II to share with DTA and Disability Evaluation Services (DES):

- my medical records;
- other information about my time in a hospital; and
- other information about any of my medical care.

I allow the medical or mental health care provider to share all information about my health. This includes information about:

- my mental health;
- my AIDS/HIV status;
- drug and alcohol abuse;
- how my health problems affect my ability to work; and
- how my health problems affect what I do every day.

✓ **Check here if you do NOT allow the medical or mental health care provider to share your AIDS/HIV status:** ☐

SECTION IV

Any medical information that the health care provider releases to DTA and the Disability Evaluation Service will continue to be protected by federal privacy laws.

I understand that I can cancel this permission at any time. I can cancel this permission by sending a letter to my medical or mental health care provider. I understand that this permission ends six months from the date I sign this Medical Records Release Form, if I do not cancel it before then.

I understand that my medical or mental health care provider may send information to DTA and DES before I cancel my permission. I understand that my medical or mental health care provider cannot get the information back after sending it.

I understand that it is my choice to let my medical or mental health care provider share medical information with DTA and DES. I do not have to give permission. I also understand that DTA and DES will decide about my disability without the information if I do not let my medical or mental health care provider share it.

SECTION V

Signature of applicant/client:	Date:

If the person signing this form has legal authority to act for the applicant/client (such as a legal guardian), give us the following information:

Signature of person completing this form:	
Printed name:	Date:
What kind of authority do you have to sign for the applicant/client?	

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City/Town	State:	ZIP:
Telephone		

(continued on back) ▶

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- how my health problems affect my ability to work; and
- how my health problems affect what I do every day.

✓ **Check here if you do NOT allow the medical or mental health care provider to share your AIDS/HIV status:** ☐

SECTION IV

Any medical information that the health care provider releases to DTA and the Disability Evaluation Service will continue to be protected by federal privacy laws.

I understand that I can cancel this permission at any time. I can cancel this permission by sending a letter to my medical or mental health care provider. I understand that this permission ends six months from the date I sign this Medical Records Release Form, if I do not cancel it before then.

I understand that my medical or mental health care provider may send information to DTA and DES before I cancel my permission. I understand that my medical or mental health care provider cannot get the information back after sending it.

I understand that it is my choice to let my medical or mental health care provider share medical information with DTA and DES. I do not have to give permission. I also understand that DTA and DES will decide about my disability without the information if I do not let my medical or mental health care provider share it.

SECTION V

Signature of applicant/client:	Date:

If the person signing this form has legal authority to act for the applicant/client (such as a legal guardian), give us the following information:

Signature of person completing this form:	
Printed name:	Date:
What kind of authority do you have to sign for the applicant/client?	

Social Security Administration

Consent for Release of Information

Form Approved
OMB No. 0960-0566

Instructions for Using this Form

Complete this form only if you want us to give information or records about you, a minor, or a legally incompetent adult, to an individual or group (for example, a doctor or an insurance company). If you are the natural or adoptive parent or legal guardian, acting on behalf of a minor child, you may complete this form to release only the minor's non-medical records. We may charge a fee for providing information unrelated to the administration of a program under the Social Security Act.

NOTE: Do not use this form to:

- Request the release of medical records on behalf of a minor child. Instead, visit your local Social Security office or call our toll-free number, 1-800-772-1213 (TTY-1-800-325-0778), or
- Request detailed information about your earnings or employment history. Instead, complete and mail form SSA-7050-F4. You can obtain form SSA-7050-F4 from your local Social Security office or online at www.ssa.gov/online/ssa-7050.pdf.

How to Complete this Form

We will not honor this form unless all required fields are completed. An asterisk (*) indicates a required field. Also, we will not honor blanket requests for "any and all records" or the "entire file." You must specify the information you are requesting and you must sign and date this form. We may charge a fee to release information for non-program purposes.

- Fill in your name, date of birth, and social security number or the name, date of birth, and social security number of the person to whom the requested information pertains.
- Fill in the name and address of the person or organization where you want us to send the requested information.
- Specify the reason you want us to release the information.
- Check the box next to the type(s) of information you want us to release including the date ranges, where applicable.
- For non-medical information, you, the parent or the legal guardian acting on behalf of a minor child or legally incompetent adult, must sign and date this form and provide a daytime phone number.
- If you are not the individual to whom the requested information pertains, state your relationship to that person. We may require proof of relationship.

PRIVACY ACT STATEMENT

Section 205(a) of the Social Security Act, as amended, authorizes us to collect the information requested on this form. We will use the information you provide to respond to your request for access to the records we maintain about you or to process your request to release your records to a third party. You do not have to provide the requested information. Your response is voluntary; however, we cannot honor your request to release information or records about you to another person or organization without your consent. We rarely use the information provided on this form for any purpose other than to respond to requests for SSA records information. However, the Privacy Act (5 U.S.C. § 552a(b)) permits us to disclose the information you provide on this form in accordance with approved routine uses, which include but are not limited to the following:

1. To enable an agency or third party to assist Social Security in establishing rights to Social Security benefits and or coverage;
2. To make determinations for eligibility in similar health and income maintenance programs at the Federal, State, and local level;
3. To comply with Federal laws requiring the disclosure of the information from our records; and,
4. To facilitate statistical research, audit, or investigative activities necessary to assure the integrity of SSA programs.

We may also use the information you provide when we match records by computer. Computer matching programs compare our records with those of other Federal, State, or local government agencies. We use information from these matching programs to establish or verify a person's eligibility for Federally-funded or administered benefit programs and for repayment of incorrect payments or overpayments under these programs. Additional information regarding this form, routine uses of information, and other Social Security programs is available on our Internet website, www.socialsecurity.gov, or at your local Social Security office.

PAPERWORK REDUCTION ACT STATEMENT

This information collection meets the requirements of 44 U.S.C. § 3507, as amended by section 2 of the Paperwork Reduction Act of 1995. You do not need to answer these questions unless we display a valid Office of Management and Budget control number. We estimate that it will take about 3 minutes to read the instructions, gather the facts, and answer the questions. **SEND OR BRING THE COMPLETED FORM TO YOUR LOCAL SOCIAL SECURITY OFFICE. You can find your local Social Security office through SSA's website at** www.socialsecurity.gov**. Offices are also listed under U.S. Government agencies in your telephone directory or you may call 1-800-772-1213 (TYY 1-800-325-0778).** You may send comments on our time estimate above to: SSA, 6401 Security Blvd., Baltimore, MD 21235-6401. ***Send only comments relating to our time estimate to this address, not the completed form.***

Social Security Administration

Consent for Release of Information

Form Approved
OMB No. 0960-0566

You must complete all required fields. We will not honor your request unless all required fields are completed. *(*Signifies a required field. **Please complete these fields in case we need to contact you about the consent form*).

TO: Social Security Administration

***My Full Name**	***My Date of Birth (MM/DD/YYYY)**	***My Social Security Number**

I authorize the Social Security Administration to release information or records about me to:

***NAME OF PERSON OR ORGANIZATION:** ***ADDRESS OF PERSON OR ORGANIZATION:**

***I want this information released because:**
We may charge a fee to release information for non-program purposes.

***Please release the following information selected from the list below:**
Check at least one box. We will not disclose records unless you include date ranges where applicable.

1. ☐ Verification of Social Security Number
2. ☐ Current monthly Social Security benefit amount
3. ☐ Current monthly Supplemental Security Income payment amount
4. ☐ My benefit or payment amounts from date _____ to date _____
5. ☐ My Medicare entitlement from date _____ to date _____
6. ☐ Medical records from my claims folder(s) from date_____ to date_____
   If you want us to release a minor child's medical records, do not use this form. Instead, contact your local Social Security office.
7. ☐ Complete medical records from my claims folder(s)
8. ☐ Other record(s) from my file (We will not honor a request for "any and all records" or "the entire file." You must specify other records; e.g., consultative exams, award/denial notices, benefit applications, appeals, questionnaires, doctor reports, determinations.)

I am the individual, to whom the requested information or record applies, or the parent or legal guardian of a minor, or the legal guardian of a legally incompetent adult. I declare under penalty of perjury (28 CFR § 16.41(d)(2004) that I have examined all the information on this form and it is true and correct to the best of my knowledge. I understand that anyone who knowingly or willfully seeking or obtaining access to records about another person under false pretenses is punishable by a fine of up to $5,000. I also understand that I must pay all applicable fees for requesting information for a non-program-related purpose.

***Signature:** _____ ***Date:** _____

****Address:** _____ ****Daytime Phone:** _____

Relationship (if not the subject of the record): _____ ****Daytime Phone:** _____

Witnesses must sign this form ONLY if the above signature is by mark (X). If signed by mark (X), two witnesses to the signing who know the signee must sign below and provide their full addresses. Please print the signee's name next to the mark (X) on the signature line above.

1.Signature of witness	2.Signature of witness
Address(Number and street,City,State, and Zip Code)	Address(Number and street,City,State, and Zip Code)