



### Voluntary Authorization to Release Information

#### Release for Designated Organization, Employer or Individual

I hereby authorize  
to release the information as requested below to the Department of Transitional Assistance.

#### Recipient Release

I hereby authorize the Department of Transitional Assistance (DTA) to contact the organization,  
employer or individual designated above regarding **SELECT**

(Any information released will be kept confidential.)

#### Explain:

Applicant/Recipient

Date

Signature

Social Security Number (Optional)

Address

City/Town

ZIP

AU Manager Name

AU Manager Signature

Date

TAO Name Address

City/Town

ZIP

AU Manager Telephone Number

Fax Number

Voluntary Authorization to Release Information is valid for 90 days from the date of the applicant/recipient signature.

**DEPARTMENT OF TRANSITIONAL ASSISTANCE**  
(Formerly Known as the "Department of Public Welfare")

REQUEST FOR ACCESS TO CLIENT RECORD OF \_\_\_\_\_  
(Client's Full Name)

1. Client Information:

Date of Birth \_\_\_\_\_ Address: \_\_\_\_\_

SS# \_\_\_\_\_

Number of Dependents \_\_\_\_\_ Categories of Assistance: \_\_\_\_\_

Full Names of Dependents:  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

2. I hereby authorize \_\_\_\_\_ (name of person and/or agency) to have access to my record on my behalf until \_\_\_/\_\_\_/\_\_\_ (date).

3. I hereby certify that I am the client named above.

\_\_\_\_\_  
Date (Client's Signature)

4. I find that the information in item 1 and the signature in item 3 match the information and signature in the client record.

\_\_\_\_\_  
Date Name of Dept. Employee (Print)

\_\_\_\_\_

Signature of Dept. Employee



# More Food Stamps for Families with Child Care Expenses

## For all low-income families:

- If you pay expenses for the care of **any child under 18 or disabled adult**, your family can receive increased food stamp benefits!
- Every **\$3** you spend on childcare may increase your Food Stamps by **\$1** – up to the maximum food stamp amount!
- You can claim any dependent care costs you incur because
  - You are working or are looking for a job
  - You are attending school or work-related training
  - You are doing volunteer work or another activity required by the Food Stamp Employment/Training Program

## Q. What can you claim as expenses?

<b>Child or Adult Care...</b>	All payments you are responsible for, including co-payments, for a child or disabled adult
<b>Out-of-School Activities for any child under 18...</b>	Any supervised activity, including before and after school, school vacation, summer camps, YMCA, and Boys/Girls Club fees
<b>Mileage (at 58.5 cents per mile)...</b>	If you drive your child to/from the child care, or camp or school program
<b>Public Transportation Costs...</b>	If you or your child takes a bus, subway, or train to/from the child care, or camp or school program

## Q. Is there a limit or cap on the expenses I can claim?

- **NO.** Effective 10/1/2008, you can **claim the full amount** of costs you pay.

*For example: A mother with two children who earns \$1800/month before taxes and pays \$600 unheated rent will get **\$208** in Food stamps. If she pays \$300/month in child care and related travel, her food stamps will go up to **\$298/month**.*

## Q. How do I claim child care expenses?

- You can claim these expenses by giving their DTA office a signed statement. DTA will ask for proofs *only if* the information you provide is questionable..A sample form is found on the back of this sheet.

## Statement of Child Care Costs for Food Stamps

### Children in child care

- |   |   |
|---|---|
| 1. _____<br>Name                      Age | 2. _____<br>Name                      Age |
| 3. _____<br>Name                      Age | 4. _____<br>Name                      Age |

*(List additional children in care on another paper.)*

### My child care costs: (This includes direct care, co-pays, camps, other payments for care)

*(Please mark one)*

I pay \$ \_\_\_\_\_/day    OR    \$ \_\_\_\_\_/week

### My transportation costs: (This includes travel to and from the child care, camp, or school programs)

#### 1. By car (DTA allows \$.58 cents per mile if you use your car)

I drive \_\_\_\_\_ miles round trip, for \_\_\_\_\_ days per week

#### 2. By public transportation

*(Please mark one)*

I pay \$ \_\_\_\_\_/day    OR    \$ \_\_\_\_\_/ week

#### ► COMPLETE THIS BOX:

My name: \_\_\_\_\_                      SSN: \_\_\_\_\_

Address: \_\_\_\_\_                      Phone: \_\_\_\_\_

\_\_\_\_\_

Signature: \_\_\_\_\_                      Date: \_\_\_\_\_

**If you have child care expenses because of work, training, or job search, tell DTA. Your monthly Food Stamp benefits may increase because of these costs. You can use this form to notify your DTA worker. Be sure to note child care costs whenever you apply or your case is reviewed.**



# Food Stamps for Elder/Disabled Households with Medical Expenses

## For All Seniors (age 60 or over) and Persons with Disabilities:

If you have out-of-pocket medical expenses, your food stamps may increase! DTA uses a \$90 deduction off monthly income if you have medical expenses of \$36 or more per month. This deduction can increase your food stamps. If you pay over \$125/month in expenses, you might get even more.

## Q. What kinds of medical related expenses can I claim?

### Basic Care costs...

If you pay directly for any medical, dental care, mental health, physical therapy, hospital based care, home health and nursing care... or pay any insurance premiums, co-payments or deductibles.

### Alternative Care...

If you pay for acupuncture, chiropractic care homeopathy or herbal treatments prescribed by a licensed practitioner

### Health Care Supplies and Equipment...

If you buy special creams, ointments, pain magnets, incontinence supplies, commodes or other supplies... or buy equipment recommended by your licensed health practitioner.

### Over-the-counter drugs...

If you buy pain relievers, insulin, antacids, vitamins, allergy pills other remedies recommended by your health practitioner.

### Mileage at 58.5 cents/mile or the cost of public transport...

If you drive your car to appointments or to pick up drugs or medical supplies at the pharmacy, you can claim 58.5 cents per mile driven -- or what you pay for a taxi, bus, subway or train.

### Housekeeper and caregiver expenses...

If you need a housekeeper or care attendant to care for you because of your age or disability.

### Vision or hearing care communication devices, other one-time expenses...

If you buy eyeglasses, contacts, hearing aides, speech or communication equipment, or have monthly usage fees, OR you pay emergency medical care not covered by insurance.

## Q. Is there a limit or cap on the expenses I can claim?

If you have proof of medical expenses over \$35/month, DTA will automatically allow a standard \$90 deduction. You need to show proofs of at least \$36 /month to get this \$90 deduction. If you have more than \$125/month in medical expenses, DTA will deduct the value of these expenses from your income, after the first \$35. There is no cap on what you can claim if you can show proof of these expenses.

*For example: A senior in public housing with no heating costs receives \$700 in Social Security, plus MassHealth. She gets only \$14/month in food stamps. She drives to 20 miles/week to the doctor and pharmacy. Because she has more than \$35/month in medical related transportation (86 miles x 58.5 cents = \$50.31) her food stamps will increase to \$43/month.*

## Q. How do I claim medical expenses?

You can claim medical expenses on your application, or you contact your food stamp worker. Be sure to keep copies of bills you pay, appointment letters that show the dates you travel. A sample checklist is on the back to help you keep track.

# FOOD STAMP MEDICAL DEDUCTIONS CHECKLIST

**MEDICAL CARE NOT REIMBURSED BY INSURANCE** (e.g., doctor/clinic visits, dental care, psychotherapy, rehabilitation, hospital or outpatient care, nursing or home health care)

Type of care	Cost/Month
	\$
	\$

**HEALTH INSURANCE** (e.g., premiums, co-payments, deductibles)

Type of cost	Cost/Month
	\$
	\$

**ALTERNATIVE HEALTH TREATMENTS** (e.g., chiropractic, acupuncture, massage therapy, Christian Science healing)

Type of treatment	Cost/Month
	\$
	\$

**TRANSPORTATION/LODGING TO OBTAIN MEDICAL TREATMENT OR SERVICES** (e.g., mileage for use of your private car at 58.5 cents per mile; actual cost of bus, subway, shuttle, or taxi)

Type of transportation	Cost/Month
	\$
	\$

**PRESCRIPTION MEDICATION**

Type of medication	Cost/Month
	\$
	\$
	\$
	\$
	\$

**OVER-THE-COUNTER MEDICATION PRESCRIBED BY A HEALTH CARE PROVIDER** (e.g., pain relievers, antacids, vitamins, insulin, herbal supplements)

Type of medication	Cost/Month
	\$
	\$
	\$

**HEALTH-RELATED SUPPLIES PRESCRIBED BY A HEALTH CARE PROVIDER** (e.g., foot care, incontinence supplies, dentures, hearing aides, batteries for hearing aides/other medically-related devices, eyeglasses, contacts, contact lens cleaning supplies)

Type of supply	Cost/Month
	\$
	\$
	\$
	\$
	\$

**HEALTH EQUIPMENT** (e.g., sick room equipment, purchase/repair of wheelchair or mobility aid, prosthetics, personal emergency response system, communication equipment for the hearing, speech or visually impaired)

Type of equipment	Cost/Month
	\$
	\$
	\$

**OTHER EXPENSES** (e.g., securing and maintaining service animals, attendant services, housekeeper)

Type of expense	Cost/Month
	\$
	\$
	\$

**TOTAL COST OF MEDICAL EXPENSES PER MONTH: \$**  

**I certify that I incur the medical expenses listed above. I have attached the receipts I have available. I request that the Department of Transitional Assistance consider these expenses when calculating my monthly food stamps, and assist me with getting any additional proofs required.**

X \_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Social Security Number

Form prepared by Massachusetts Law Reform Institute (10/08)

## Landlord Verification Form

This is an optional form.

To verify **shelter costs**, a household may elect to use this form **or** may provide a copy of a lease, cancelled rent check, money order or other acceptable proof of rent.

To verify **heating, cooling costs separate from rent**, a household may elect to use this form **or** may provide a copy of fuel or utility service bills or other proof that the household incurs costs for heating or cooling (air conditioning). Where the household does not incur separate heating or cooling expenses, a household can use this form or utility bills to verify **any other utilities separate from rent** (e.g. cooking fuel, electricity for lights, water, sewerage, garbage collection, trash collection, telephone (including cell phones)).

To verify **residence** (your address), the household may elect to use this form **or** may provide other documents that confirm the household's home address including utility bills, wage stubs or statements from employers, health insurance statements, driver's license, school ID, or other acceptable proof of where the household lives.

DTA rules for required verifications and alternative verifications are found at 106 CMR 361.610. Check with the DTA worker regarding other acceptable proof of shelter costs or residency.

### Part I (to be completed by the tenant):

- Enter the name and address of the tenant

### Part II (to be completed by the landlord or property manager).

Please complete the following sections:

- Rental Information (A);
- Utility Information (B); and
- Landlord/Property Manager Information (C).

Produced by the Massachusetts Law Reform Institute, July 2007

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## Landlord Verification

(This is an optional form. A copy of a lease, money order for rent, cancelled rent check, or other proof of shelter expenses is also acceptable proof of shelter costs.)

### Part I

\_\_\_\_\_  
Tenant's Name

\_\_\_\_\_  
Tenant's Address

\_\_\_\_\_  
City/Town

\_\_\_\_\_  
Zip

### Part II (TO BE COMPLETED BY THE LANDLORD or PROPERTY MANAGER)

#### A. Rental Information

1. To the best of my knowledge, the above-named person is a current tenant at the above address.  Yes  No
2. The total rent for this address is \$ \_\_\_\_\_ per  month  week  other \_\_\_\_\_ (specify)

3. Is the rental property public housing?  Yes  No
4. Is the rent subsidized?  Yes  No **If yes, is the subsidy**  Section 8  Mass. Rental Voucher Program?  
 Other \_\_\_\_\_
5. **If subsidized, subsidy payment \$** \_\_\_\_\_ **Tenant Payment \$** \_\_\_\_\_

#### B. Utility Information

- 6.a. Does the tenant incur any expense SEPARATE from the rent for either of the following?  Heating  Cooling/AC
- 6.b. Does the Tenant incur an expense SEPARATE from the rent for any other utility\*?  Yes  No  
(\* such as electricity for lights, cooking gas, water, trash removal, other utility service)

#### C. Landlord/Property Manager Information

**Please sign and date this form.**

Landlord's or Property Manager's Signature \_\_\_\_\_ Date \_\_\_\_/\_\_\_\_/\_\_\_\_

Landlord's or Property Manager's Name (print) \_\_\_\_\_

Landlord's or Property Manager's Address \_\_\_\_\_

Landlord's or Property Manager's daytime telephone number (\_\_\_\_) \_\_\_\_\_ - \_\_\_\_\_

## Shared Housing Verification

(This is an optional form. A copy of a money order for rent, cancelled rent check, or other proof of shelter expenses is also acceptable proof of shelter costs.)

### Part I

\_\_\_\_\_  
Name of head of household sharing expenses with the person named in Part II.

\_\_\_\_\_  
Street Address

\_\_\_\_\_  
City/Town

\_\_\_\_\_  
Zip

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### Part II (TO BE COMPLETED BY THE HEAD OF THE HOUSEHOLD SHARING EXPENSES WITH THE PERSON NAMED ABOVE.)

1. The person named above pays:

•Rent/mortgage  Yes  No Amount \$ \_\_\_\_\_ per \_\_\_\_\_

2. The person named above pays these utilities separate from rent:

•Heating or cooling costs (e.g. air conditioning)  Yes  No

•Other utilities such as gas, electric (lights), water, sewage  Yes  No

•Telephone  Yes  No

3. The person named above

•Rents a room only (a roomer)?  Yes  No

•Gets meals provided (a boarder)?  Yes  No If yes, how many meals per week? \_\_\_\_\_  
Amount paid for these meals is \$ \_\_\_\_\_

4. Do you purchase and prepare more than half of your daily meals together  Yes  No  
with the person named above?

5. Is the housing you live in either:

•Public Housing?  Yes  No

•Section 8 or Massachusetts Rental Voucher Program Housing?  Yes  No

**Please sign and date this form.**

\_\_\_\_\_  
Name (Please print or type)

\_\_\_\_\_  
Signature

\_\_\_\_/\_\_\_\_/\_\_\_\_  
Date

MLRI- July 2007





Massachusetts Department of Transitional Assistance  
REQUEST FOR AN ADA ACCOMMODATION

- Initial Request
- Modification of Initial Request

\_\_\_\_\_  
TAO

\_\_\_\_\_  
Date

\_\_\_\_\_  
Applicant/Client Name

\_\_\_\_\_  
SSN

\_\_\_\_\_  
Street Address/City/ZIP

**Reason for ADA Accommodation Request**

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

**Requested ADA Accommodation**

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

\_\_\_\_\_  
**Applicant/Client Signature**                      **Date**                      **Case Manager Signature**                      **Date**

The Department has thirty (30) days to make a decision on your request. If a decision is not made within thirty days, you may file your accommodation request directly with the Central Office Accommodation Appeal Committee. Please see the back of this form. The Appeal Committee will have ten (10) days to make its decision.

If you have trouble reading or understanding this notice, please feel free to call Recipient Services at 1-800-445-6604. We can help explain it to you.

**Decision:**     **Approved**                       **Denied**

Approved Accommodation (if any):

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

Reason for denial, if applicable: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**IMPORTANT: If you disagree with the decision reached by the TAO Accommodation Team you have the right to reconsideration by the Central Office Accommodation Appeal Committee. You must make your request for reconsideration within 45 days of this decision. Please see the back of this form.**

\_\_\_\_\_  
**Department Representative Signature**

\_\_\_\_\_  
**Date**