Attachment A

# Food Stamp Program Work Requirement Medical Report

*Massachusetts Department of Transitional Assistance*

**Patient/Participant Name** _____

**Address** _____

_____

The above listed individual requests verification of their medical condition and/or participation in your program. Please complete this form. You or the patient/participant should return it to the following DTA address: _____

**Patient/participant's authorization**

I hereby authorize the release of medical information and/or rehabilitation participation requested to the Department of Transitional Assistance.

Signature _____ Date ___/___/_____

Please answer **one** or **more** of the following questions in the box below. Please sign and date this form including your profession or position in your agency.**

1) Is this individual pregnant? ☐ yes ☐ no ☐ unknown If **yes**, due date? ___/___/_____

2) Is individual a **participant in a vocational rehabilitation program, a mental health counseling program, or a drug or alcohol treatment or counseling program**? ___yes ___no If yes, duration of program _____

3) Does this patient have **a mental and/or physical illness or disability, temporary or permanent**, which reduces his or her ability to financially support him or herself? __yes ___no

If **yes**, please indicate the **duration** of the patient's illness/disability

☐ less than 30 days ☐ more than 30 days

☐ more than 6 months ☐ more than 12 months/or indefinite

I certify that the information provided above is true and accurate.

_____ _____ ___/___/_____

Name (please print) Title/profession** Date form signed

_____ _____

Signature Address Phone

** This form may be signed by any of the following: physician, physician's assistant, designated representative of the physician's office, nurse practitioner, osteopath, licensed or certified psychologist, drug and alcohol abuse counselor, certified mental health counselor, licensed independent clinical social worker, licensed certified social worker, and certified midwife. For purposes of verifying an individual's participation in a rehab or counseling program (question #2), the director of the program or the individual's counselor may also sign this statement.

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