Massachusetts Department of Transitional Assistance
Supplemental Nutrition Assistance Program

ABAWD Work Program Requirement Medical Report

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.

Patient/Participant Name _____

Address _____

_____

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

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 ___/____/_____

Agency ID or Last 4 digits of SSN: _____

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, anticipated program end date: _____
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 ❒ 1-3 months ❒ 3-6 months
   - ❒ 6 -9 months ❒ 9-12 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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