Massachusetts Department of Transitional Assistance

Good Cause Medical Statement

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

Client name _____ Agency ID or last 4 of SSN _____

Patient name (if different) _____ Patient date of birth _____

For the patient: You asked for a disability exemption from the TAFDC time limit and work requirement. Because DTA's Disability Evaluation Service (DES) denied your disability claim before, you will not be exempt unless DES decides you are disabled. However, if a medical provider completes this form, the TAFDC work requirement will not affect you while DES is making a decision.

Patient Authorization

I authorize release of the information requested on this form to the Department of Transitional Assistance.

Patient signature _____ Date _____

For the Medical Provider: Please complete the form below and return to the patient or send directly to DTA. A doctor, nurse practitioner, osteopath, or psychologist licensed in Massachusetts may sign this form.

Medical Information

Diagnosis	Onset date (if known)	Date of diagnosis	How long is condition expected to last?

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Date of most recent medical exam: _____

Have you ever examined or treated this patient before? ____ Yes ____ No If yes, when?_____

Are any of the conditions listed above the result of an accident? ____ Yes ____ No

Impact on Work Activities

Does a physical or mental condition or cognitive impairment prevent this patient from consistently meeting the TAFDC work program requirement of ____ hours each week? (To meet this requirement, clients may do paid work, volunteer work, attend school or a training program, or do job search.) ____ Yes ____ No

If yes, please explain why the patient cannot do the required hours of work activities:_____

_____

_____

How many hours each week can this patient consistently work or participate in an activity? _____

If the patient can work some hours, list any restrictions on activities: _____

_____

Signature

_____

Medical provider signature Date

_____

Medical provider name and title

_____

Board of Registration Number

_____ _____

Address Telephone number