



Massachusetts Department of Transitional Assistance

Food Stamp Disability Verification for Elderly Noncitizens

Section I: Medical Release

By signing below I authorize release of the medical information in Section II of this form to the Department of Transitional Assistance.

Applicant's Printed Name

Applicant's Signature

Social Security Number

Address

City/Town

ZIP

Section II: Medical Practitioner's Statement

To qualify for food stamps, the individual named above needs to verify that she or he is disabled.

For this purpose, disability is defined as (1) having a severe physical or mental impairment, (2) that has lasted or is expected to last for 12 months or result in death, and (3) that makes the person unable to engage in past work or in any other substantial work in light of the person's age, education, and work experience.

Disability must be verified by a licensed medical practitioner.

We appreciate your completing this form. **All parts *must* be completed.**

Diagnoses:

- _____
- _____
1. Is/are the impairment(s) severe (more than slight)? Yes No
 2. Will the impairment(s) last 12 months or result in death? Yes No
 3. Is this person unable to perform substantial gainful employment on a sustained basis in light of the individual's physical and/or mental impairment(s), age, education, language barriers and work experience? Yes No

If this person cannot perform substantial gainful employment, explain (*must* be completed):

I certify that I am a licensed medical practitioner, that I have examined the above individual, and that the information provided is true and accurate.

Name (please print) _____ Title _____

Address _____ Telephone Number _____

Signature _____ Date _____



Departamento de Asistencia Transicional de Massachusetts

Verificación de discapacidad para personas mayores no ciudadanos que solicitan Cupones de Alimentos

Sección I: Autorización del historial médico

Al firmar abajo, autorizo la entrega del historial médico ubicado en la Sección II de este formulario al Departamento de Asistencia Transicional.

Nombre del Solicitante (en letra de imprenta)

Firma del Solicitante

Número Seguro Social (SSN)

Dirección

Ciudad/Pueblo

Código Postal

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