Massachusetts Department of Transitional Assistance

SNAP 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 Supplemental Nutrition Assistance Program (SNAP) benefits, 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 Beneficios de SNAP

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

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_____