Commonwealth of Massachusetts
Executive Office of Health and Human Services
Department of Transitional Assistance
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Field Operations Memo 2004-22
May 21, 2004

To: **Transitional Assistance Office Staff**

From: **Cescia Derderian, Assistant Commissioner for Field Operations**

Re: **Food Stamp Work Requirements Medical Report**

Overview

USDA recently clarified that individuals claiming an exemption from the Food Stamp Work Requirement due to being *unfit for work* in accordance with 106 CMR 362.310(B)(3) and 106 CMR 362.320(B)(4), need not prove a disability. For Food Stamp Work Requirements purposes, *Unfit for Work* means, the individual has a physical or mental illness or impairment that reduces his or her ability to financially support him or herself. An AU Manager can make such a determination if it is "obvious" to the AU Manager that the individual is *unfit for work.* For example, a recent amputee who is recovering from surgery may be deemed *unfit for work*.

In addition, outreach discussion with shelters for the homeless and advocate groups have revealed that the current food stamp medical form does not adequately address the issue of being *unfit for work.* The revised form is now able to document a disability as well as *unfit for work*.

Purpose of Memo

This memo transmits the new Food Stamp Work Requirements Medical Form (FSPWR-MED 5/2004) and provides instructions for using the form. See *Attachment A*.

Unfit for Work as a *FS Work Program or a FS ET Exemption*

The Food Stamp Work Requirement Medical Form may be used to verify that a food stamp applicant/recipient is *unfit for work* due to one or more of the following situations:

- pregnancy;
- participation in a vocation or rehabilitation program;

Unfit for Work as a *FS Work Program or a FS ET Exemption (Continued)*

- participation in mental health counseling;
- participation in a drug or alcohol treatment program; and
- a mental or physical illness which reduces the individual's ability to financially support him or herself.

Note: An individual who is FS Work Program required or FS/ET required may also verify that he or she is *unfit for work* using a letter or form from a competent medical authority or facility providing services.

The new Food Stamp Work Requirements Medical Report will be distributed to homeless shelters, community agencies and outreach partners throughout the Commonwealth. TAO staff must make the form available to an individual claiming a Work Requirement exemption for a mental or physical illness, disability (temporary or permanent), which results in the individual being *unfit for work* and encourage him or her to have this form completed.

Obsolete

The *FS-MED (revised 3/97)* form is now obsolete.

Questions

If you have any questions, please have your Hotline designee call the Policy Hotline at 617-348-8478.

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.

FSPWR-MED (5/2004)
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