Medical Certification for Medicaid Work Requirement Exemption

Date: _____

Patient Name: _____
Date of Birth: _____

To Whom It May Concern:

Barth syndrome is a lifelong genetic disorder resulting in significant cardiac, muscular, and metabolic impairment. Due to chronic fatigue, muscle weakness, exercise intolerance, and the risk of serious medical complications, the patient is unable to reliably perform or sustain work-related activities. In my medical judgment, the patient meets criteria for exemption from Medicaid work requirements.

This letter is to certify that the patient has been diagnosed with **Barth syndrome**, a rare genetic disorder that affects multiple body systems, including the heart, skeletal muscles, immune system, and overall energy production.

Barth syndrome is associated with significant medical complications that may include:

- Cardiomyopathy and heart failure risk
- Severe fatigue and exercise intolerance
- Muscle weakness
- Recurrent infections due to neutropenia
- Physical limitations affecting endurance and daily functioning
- Need for ongoing medical monitoring, treatment, and specialist care

As a result of these medical impairments, the patient has substantial limitations in their ability to engage in employment, job training, work-search activities, or other activities required under Medicaid work participation programs. The patient's condition is chronic and may fluctuate in severity, but it significantly restricts their capacity to maintain consistent work-related activities.

Consequently, this patient qualifies for a **medical exemption from Medicaid work requirements**. Participation in mandatory work activities may worsen the patient's health status and interfere with necessary medical treatment and disease management.

I recommend that the patient be granted a permanent exemption from Medicaid work requirements.

☐ 12 months
☐ Permanently, due to the chronic nature of the condition
☐ Other: _____

Should additional medical information be required, please contact my office.

Sincerely,

Provider Name, Credentials
Medical Practice/Facility
Phone Number
Fax Number
NPI Number