W-300 (Rev. 3/01)

State of Connecticut
DEPARTMENT of SOCIAL SERVICES

MEDICAL REPORT

(for Medicaid Disability and SAGA Cash Benefits)

PLEASE RETURN THIS FORM TO:	CCC USE ONLY:
DSS worker:	Date received:
Address:	Date due:
Phone:________ FAX:________	Tracking number:

****

Dear Medical Provider: The person named below states that he or she has physical and/or mental health problems that prevent employment. Please complete this form if you are treating this person so that we may verify eligibility for Medicaid disability or SAGA unemployability benefits. Please complete the general information in Section A, then continue on to other sections only if they are relevant to the conditions for which you are providing treatment. **Instructions for completion of this form and billing/payment are on page 2.** Return the completed form to the DSS worker named above.

PATIENT NAME:____________________

ADDRESS:____________________

____

DATE OF BIRTH:____________________

DSS CLIENT ID#:____________________

SSN:____________________

PHONE:____________________

GENDER: MALE ☐ FEMALE ☐

RELEASE OF INFORMATION

Name of Doctor, Clinic or Hospital____________________

I hereby authorize the medical professional named above to release or disclose to the State of Connecticut Department of Social Services, the Norwich General Assistance office, and/or Colonial Cooperative Care, Inc. the following information:

> All medical records or other information regarding my treatment, hospitalization and/or outpatient care for my condition including: psychological and psychiatric impairments, drug and alcohol abuse, sickle cell anemia, AIDS, sexually transmitted diseases, tests for HIV, and how my health problems affect my activities of daily living and my ability to work.

I authorize a photocopy or fax of this release to be accepted with the same authenticity as the original. I understand I may withdraw this authorization in writing at any time, except for action already taken. Unless I have cancelled it, this authorization will expire when a determination is made in regard to my eligibility for Medicaid disability and/or SAGA unemployability benefits.

____________________________ ________________

Signature of Patient or Other Legal Representative Date

Dear Medical Provider,

The individual named on the reverse has applied for Medicaid disability and/or SAGA cash unemployability benefits. **To qualify, the individual must demonstrate that he/she has a severe mental and/or physical impairment, or combination of impairments, that will preclude employment for at least six months (SAGA) or 12 months (Medicaid).**

- We need objective medical evidence, including copies of any diagnostic test results that substantiate the listed conditions. If you recently submitted this information to the Social Security Administration, or if your progress notes provide this information, you may substitute copies of those materials.
- We are also interested in how the patient's symptoms, including possible side effects of medication, affect his/her **ability to perform ADLs** and **function in the workplace**. Specifically, **what can the patient no longer do as a result of his/her health problems?**
- Often, applicants have multiple conditions that individually do not affect employability. However, the **combined effect of multiple conditions** may severely impact the individual's ability to work. Please address such effects if applicable.
- Applicants may have chronic conditions of **mild or moderate severity that substantially deteriorate** over time. If this is the case, please indicate how and over what period of time the condition has worsened, including prognosis for the future.
- Always complete Section A, (General Information). Otherwise, you need only complete the sections of this form that are relevant to this patient.
- If you know that other providers are treating this individual, please advise us so we may contact them. Likewise, if you are aware of diagnostic tests taken but you do not have those test results, please note from whom they may be obtained.
- Please do not hesitate to contact the worker listed on the front page if you have any questions. And, **THANK YOU** for taking the time to provide information on behalf of your patient. Please refer to the billing and payment instructions below.

Billing and Payment Instructions

After submitting the requested medical information, please submit your claim to:

EDS
P.O. BOX 2941
HARTFORD, CT 06404

Submit your claim on a standard **HCFA 1500** form. **IMPORTANT:** You must attach form **W-513**, "Examination Request for Medical Eligibility Determination" to the HCFA 1500 in order to be paid.

Section A. GENERAL INFORMATION

1. What conditions are you treating this patient for?

   Diagnoses: 1.________________ 2.________________ 3.________________

2. Does this condition, or combination of conditions, **prevent the patient from working at this time?**

   YES ☐ NO ☐

   IF "NO," GO DIRECTLY TO THE SIGNATURE (LAST) PAGE OF THIS FORM.
   IF "YES," PLEASE CONTINUE TO QUESTION 3.

3. How long do you expect that the patient will be unable to work?

   Less than 2 mos. ☐ 2 or more but less than 6 mos. ☐ 6 mos. or more ☐ 12 mos. or more ☐

4. Please summarize the patient's diagnosis, symptoms and prognosis as these relate to his/her ability to work. Consider the effects of medications the patient may be taking for these conditions. ________________

5. Check one: ☐ This is a new condition (approximate onset: ________________)
   ☐ This is a pre-existing condition (approximate onset: ________________)

6. If this condition has recently deteriorated, please explain below.

IF THE PATIENT HAS MENTAL HEALTH OR SUBSTANCE ABUSE ISSUES ONLY, WITH NO SIGNIFICANT PHYSICAL INVOLVEMENT, PLEASE SKIP TO SECTION D., "MENTAL STATUS INFORMATION", ON PAGE 6.

Section B. CLINICAL INFORMATION

1. Date first seen ______________________ 2. Date last seen ______________________

3. Enter (or substitute office notes): **Height** ________ **Weight** ________ **Blood pressure** ________

4. Are there indications of mental health issues or substance abuse? YES ☐ NO ☐ UNKNOWN ☐
   If yes, please be sure to also complete the "Mental Status Information," Section D, on page 6.

5. Please enter objective clinical findings in the following table (or substitute office notes).

DIAGNOSIS	SUPPORTING SYMPTOMS	OBJECTIVE FINDINGS	Supportive test results (enter test, date of test and results or attach actual test results)
Primary: Onset: ___/___/___			
Secondary: Onset: ___/___/___			
Secondary: Onset: ___/___/___			
Other: Onset: ___/___/___			

Section C. PHYSICAL CAPACITIES EVALUATIONS

1. In terms of the patient's ability to perform during an 8-hour workday with <u>normal breaks</u>, the patient can:

Activity	Unknown	N/A	No restrictions	Never	1 hour	2 hours	3 hours	4 hours	5 hours	6 hours	7 hours	8 hours
Sit												
Stand												
Walk												

2. The patient can LIFT:

Weight patient can LIFT	Unknown	N/A	No restrictions	Never	Occasionally (1 - 33% of time on job)	Frequently (34 - 66% of time on job)	Continuously (67 - 100% of time on job)
Up to 5 lbs.							
6 - 10 lbs.							
11 - 20 lbs.							
21 - 25 lbs.							

3. The patient can CARRY:

Weight patient can CARRY	Unknown	N/A	No restrictions	Never	Occasionally (1 - 33% of time on job)	Frequently (34 - 66% of time on job)	Continuously (67 - 100% of time on job)
Up to 5 lbs.							
6 - 10 lbs.							
11 - 20 lbs.							
21 - 25 lbs.							

4. The patient can use **hands** for **repetitive action** such as: (check one)

HAND	SIMPLE GRASPING?			PUSHING & PULLING OF ARM CONTROLS?			FINE MANIPULATION?		
	YES	NO	UNKNOWN	YES	NO	UNKNOWN	YES	NO	UNKNOWN
RIGHT									
LEFT									

5. The patient can use **feet** for **repetitive movement** as in pushing & pulling of leg controls:

FOOT	CAN PUSH & PULL CONTROLS?			
	YES	NO	UNKNOWN	COMMENTS
RIGHT				
LEFT				
BOTH				

6. The patient is able to:

Activity	Unknown	N/A	No restrictions	Never	Occasionally (1 - 33% of time on job)	Frequently (34 - 66% of time on job)	Continuously (67 - 100% of time on job)
Bend							
Squat							
Crawl							
Climb							
Reach							

7. To what extent can the patient be involved in the following activities? (check one)

Activity	Unknown	N/A	No restrictions	Never	Occasionally (1 - 33% of time on job)	Frequently (34 - 66% of time on job)	Continuously (67 - 100% of time on job)
Unprotected heights							
Being around moving machinery							
Exposure to marked changes in temperature & humidity							
Driving automotive equipment							
Exposure to dust & fumes							

8. AMBULATION: Please list any assistive equipment (cane, walker, etc.) required to perform any activities listed in this section of the form. ______________________

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Section D. MENTAL STATUS INFORMATION

\- Complete this section if this patient has mental health issues that affect his/her ability to work. These may range from situational anxiety or mild depression to clinical depression or chronic, severe mental illness, and/or substance abuse. Some individuals seek treatment for these conditions from their primary care physician or general practitioner rather than mental health clinicians. If you are other than a mental health clinician, you may skip question 5 unless you have access to this information.

1. Does this person have mental health or substance abuse issues that impact his/her ability to work?
   YES ☐ NO ☐ UNKNOWN ☐

   IF YOU ANSWERED "NO" or "UNKNOWN," GO DIRECTLY TO SECTION F. ON PAGE 9.

2. If you answered "YES," please summarize the patient's diagnosis, symptoms and prognosis as they affect his/her ability to work. Consider the effects of medications the patient may be taking for this condition.

   ____

   ____

   ____

3. Is this disorder: A single episode ☐ Exacerbation of a chronic mental illness ☐

4. If it is a recurrence, is there a cyclical pattern? YES ☐ NO ☐

   If yes, how frequent? ______________________

5. Please provide all five axes of a DSM-IV diagnosis, if you know:
Axis I ____________ Axis II ____________ Axis III ____________ Axis IV ____________
Axis V GAF score: current ________ highest level in the past year ________

Section E. MENTAL RESIDUAL FUNCTIONAL CAPACITY ASSESSMENT

1. Understanding and Memory

FUNCTION Patient has the ability to:	NOT SIGNIFICANTLY LIMITED (can consistently & usefully perform)	MODERATELY LIMITED (capacity to perform the activity is diminished)	MARKEDLY LIMITED (cannot usefully perform or sustain the activity)	NO EVIDENCE OF LIMITATION IN THIS CATEGORY
Remember locations & work-like procedures				
Understand & remember very short & simple instructions				
Understand & remember detailed instructions				

2. Sustained concentration and persistence

FUNCTION Patient has the ability to:	NOT SIGNIFICANTLY LIMITED (can consistently & usefully perform)	MODERATELY LIMITED (capacity to perform the activity is diminished)	MARKEDLY LIMITED (cannot usefully perform or sustain the activity)	NO EVIDENCE OF LIMITATION IN THIS CATEGORY
Carry out very short & simple instructions				
Carry out detailed instructions				
Maintain attention & concentration for extended periods				
Perform activities within a schedule, maintain regular attendance, be punctual within customary tolerances				
Sustain an ordinary routine without special supervision				
Work in coordination with or proximity to others without being distracted by them				
Make simple work-related decisions				
Complete a normal workday and workweek without interruptions from psychologically based symptoms and perform at a consistent pace without an unreasonable number and length of rest periods.				

3. Social Interaction

FUNCTION Patient has the ability to:	NOT SIGNIFICANTLY LIMITED (can consistently & usefully perform)	MODERATELY LIMITED (capacity to perform the activity is diminished)	MARKEDLY LIMITED (cannot usefully perform or sustain the activity)	NO EVIDENCE OF LIMITATION IN THIS CATEGORY
Interact appropriately with the general public				
Ask simple questions or request assistance				
Accept instructions and respond appropriately to criticism from supervisors				
Get along with co-workers or peers without distracting them or exhibiting behavioral extremes				
Maintain socially appropriate behavior and adhere to basic standards of neatness & cleanliness				

4. Adaptation

FUNCTION Patient has the ability to:	NOT SIGNIFICANTLY LIMITED (can consistently & usefully perform)	MODERATELY LIMITED (capacity to perform the activity is diminished)	MARKEDLY LIMITED (cannot usefully perform or sustain the activity)	NO EVIDENCE OF LIMITATION IN THIS CATEGORY
Respond appropriately to changes in the work setting				
Be aware of normal hazards and take appropriate precautions				
Travel in unfamiliar places or use public transportation				
Set realistic goals or make plans independently of others				

Section F. HOSPITALIZATIONS AND IN-PATIENT TREATMENT

Please list hospitalizations and other inpatient admissions within the last 5 years. **(Include medical and mental health admissions.)**

DATES OF HOSPITALIZATION	FACILITY	REASON FOR ADMISSION AND TREATMENT RECEIVED

Section G. OUTPATIENT TREATMENT

Please indicate outpatient treatments received within the last five years (other than routine office visits).

TREATMENT	DATE(S)	DESCRIPTION/COMMENTS
Routine office visits only		
Rehabilitation (PT, OT, speech, etc.) please describe		
Counseling		
Dialysis		
Chemotherapy		
Radiation		
Other: ____________		
Other: ____________		
Other: ____________		

Section H. MEDICATIONS

Please list all prescribed drugs that alone, or in combination with other drugs, may affect the patient's ability to work.

MEDICATION	COMPLIANT WITH MEDS?	Please note any effects of this medication that impact this patient's ability to work, e.g., significantly high dosage, severe side effects, etc.
	YES ☐ NO ☐ Unknown ☐	
	YES ☐ NO ☐ Unknown ☐	
	YES ☐ NO ☐ Unknown ☐	
	YES ☐ NO ☐ Unknown ☐	
	YES ☐ NO ☐ Unknown ☐	
	YES ☐ NO ☐ Unknown ☐	
	YES ☐ NO ☐ Unknown ☐	

SIGNATURE INSTRUCTIONS

THANK YOU for taking the time to complete this form on behalf of your patient who has applied for assistance. Please print (or stamp) your name and sign below. This form may be signed by an **M.D., D.O., Ph.D.** or, for diseases or injuries of the foot, a **Podiatrist**. If you are **another type of medical professional**, e.g., a nurse practitioner or physician's assistant, you may complete this form but it must be **co-signed** by an M.D., D.O., Ph.D. or Podiatrist.

____

Name of Person Completing This Form (print) Title Signature

____

Name of Co-signer, if required (print) Title Signature

______________________ ______________________

Provider type (specialty) Date

Telephone: ______________________ FAX: ______________________