W-303
(Rev. 3/01)

State of Connecticut
DEPARTMENT OF SOCIAL SERVICES

CLIENT SUPPLEMENT

(for Medicaid Disability and SAGA Cash Benefits)

INSTRUCTIONS TO APPLICANT: You have told us that you are unable to work because of your health problems. Please use this form to tell us how your health problems keep you from working. This is your chance to tell us everything you want us to know about your health problems.

If you need help filling out the form, we will refer you to someone who can assist you.

Part A. APPLICANT INFORMATION:

NAME: ______________________ DSS CLIENT ID#: ______________________
ADDRESS: ______________________ SSN: ______________________
______________________ PHONE: ______________________
DATE OF BIRTH: ______________________ SEX: MALE ☐ FEMALE ☐

1. Describe your health problems. ______________________

2. Tell us how these health problems keep you from working. ______________________

3. Tell us which doctors and clinics you are seeing for these health problems. Attach additional sheets if necessary. **Please be sure to sign a W-303A "Authorization to Release Information from Examining Physician" form for each of the doctors and clinics you list here.**

Please list your health problems (such as arthritis, heart problem, HIV, back, depression, etc.)	Name of doctor or clinic that is treating you for this problem	Address of doctor or clinic (street, city and state)	When did you see this doctor or clinic and when is your next appointment?
			Date first seen:____ Date last seen:____ Next appointment:____
			Date first seen:____ Date last seen:____ Next appointment:____
			Date first seen:____ Date last seen:____ Next appointment:____
			Date first seen:____ Date last seen:____ Next appointment:____

4. In the last year, have you had an **overnight stay in the hospital** or have you been seen in a hospital **emergency room** because of your health problems? Attach additional sheets if necessary. **Be sure to sign a W-303A "Authorization to Release Information from Examining Physician" form for each of these hospitals.**

Name of Hospital	Address of Hospital (city and state)	Reason for hospital visit	Date of inpatient admission or emergency room visit

5. Have your health problems become worse lately? **Yes** ☐ **No** ☐ If yes, please explain. ________________

6. Are you taking any medications for your condition? **Yes** ☐ **No** ☐
   If yes, and you know the names of these medications, please list them here ________________

Part B. GENERAL INFORMATION

1. Are you right-handed or left-handed? Right-handed ☐ Left-handed ☐

2. Do you speak and understand English? Yes ☐ No ☐
   - If no, what is your primary language? ________________
   - Do you need an interpreter? Yes ☐ No ☐

3. Do you: (check one) live alone ☐ live with friends or family ☐ other ☐ ________________

4. What is your living arrangement? (check one)
   - Home or apartment ☐
   - group home or halfway house ☐
   - nursing home ☐
   - homeless ☐ If homeless, do you live in an emergency shelter? Yes ☐ No ☐
   - other (please describe)________________

5. Are you able to drive a car? Yes ☐ No ☐

6. How do you get from one place to another? (check all that apply)
   - Drive a car ☐
   - Take a bus ☐ Do you transfer from one bus to another? Yes ☐ No ☐
   - Walk ☐
   - Train or cab ☐
   - Dial-a-Ride ☐
   - Ride with friends or relatives ☐
   - Do you need help getting in and out of a car, bus, van, etc.? Yes ☐ No ☐

7. What is your height without shoes? ________ feet ________ inches

8. What is your weight without shoes? ________ pounds

9. Do you have problems seeing? Yes ☐ No ☐ If yes, do you wear glasses or contacts? Yes ☐ No ☐
   Do you have problems seeing even when you wear your glasses or contacts? Yes ☐ No ☐

10. Do you have problems hearing? Yes ☐ No ☐ If yes, do you wear a hearing aid? Yes ☐ No ☐

Part C. BEHAVIORAL HEALTH

1. Are you having any of the following problems?

PROBLEM	YES	NO	PROBLEM	YES	NO
Feel sad a lot of the time			Have panic attacks		
Have problems sleeping (sleep too much or too little; awaken in the night)			Have problems concentrating or thinking		
Loss of interest in activities I usually like			Hear voices when no one is there		
Feel guilty or worthless			See things that others don't see		
Changes in appetite (eat too much or too little)			Feel nervous or anxious (worried) all the time		
Think people are trying to hurt me in some way			Have certain routines (for example, washing your hands) that you must do over and over		
Loss of energy			Think of hurting myself		
Much more energy than usual			Think of hurting others		

2. Do you drink alcohol? Yes ☐ No ☐
   If yes, how much and how often? ______________________

3. Do you use drugs? Yes ☐ No ☐
   If yes, what kind? ______________________
   How often? ______________________

4. Have you received treatment for drugs or alcohol in the past two years? Yes ☐ No ☐
   If yes, please describe ______________________

Part D. Activities

1. How often can you do the following activities? (Check "often", "sometimes", or "never" after each activity.)

Activity	Often	Sometimes	Never	Activity	Often	Sometimes	Never
Sitting				Lifting			
Standing				Grasping			
Walking				Pushing			
Bending				Pulling			

2. Can you do any of the following household activities? (Check "yes", "no", or "need help" after each activity.)

Activity	Yes	No	Need help	Activity	Yes	No	Need help
Shop for food				Mop and sweep			
Plan meals				Make beds			
Cook				Empty trash			
Wash dishes				Mow the lawn			
Do laundry				Shovel snow			
Vacuum				Count change			

3. Do you regularly do any of the following activities? (Check "yes", "no", or "need help" after each activity.)

Activity	Yes	No	Need help	Activity	Yes	No	Need help
Read				Exercise			
Watch TV				Play games			
Play sports				Talk on the phone			
Listen to music				Do arts & crafts			
Ride a bicycle				Paint or draw			
Visit people				Knit or crochet			
Eat in restaurants				Sew			
Surf the internet				Go to a movie			
Play video games				Go to church			
Lift weights				Attend meetings			
Walk				Go hunting			
Jog (run)				Go fishing			

4. Do you have problems with any of the following activities?

Activity	No problems	Some problems	Many problems	Please describe the problems you are having in each area.
Paying attention				
Learning new things				
Remembering				
Organizing				
Listening				
Reading				
Getting along with others				
Going outside				

Part E. Education and Training

1. What is the highest grade you completed in school? (check one)

None	Grade school:								High school:				GED:	College:			
0	1	2	3	4	5	6	7	8	9	10	11	12		1	2	3	4 or more
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

   Approximate date completed: ____________________

2. Were you in special education classes? Yes ☐ No ☐ If yes, please tell us when you were in special education classes and the type of program you attended. ____________________

   ____

3. Did you ever have vocational training (e.g., electrician, truck driving, hair dressing, computer programming, cook, etc.?) Yes ☐ No ☐ If yes, please tell us when you were in vocational training and the type of program you attended. ____________________

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Part F. Work History

1. Please answer the following questions about your work history.
   - Have you ever worked outside the home? Yes ☐ No ☐
   - If you have never worked, please explain why. ____________________
   - Are you working now? Yes ☐ No ☐
   - If no, when did you stop working? __________ Month __________ Year
   - When did your health problems begin? __________ Month __________ Year
   - Did you work at any time after your health problems began? Yes ☐ No ☐
   - If yes, did your health problems cause you to:
     - Work fewer hours? ☐
     - Change your job duties? ☐
     - Change jobs? ☐
     - Other (please describe) ____________________

2. List the jobs you have had in the last 15 years. (You may use the back of page 7 if you need more paper.)

JOB TITLE (e.g., cook, truck driver, nurse, secretary, etc.)	TYPE OF BUSINESS (e.g., restaurant, factory, laundry, grocery store, etc.)	Dates worked (month and year)		Hours per day	Days per week	RATE OF PAY	
		From	To			Amount	Per day, week, month or year
						$	
						$	
						$	
						$	
						$	
						$	
						$	

3. Describe the **job** that you did the **longest** or the one that you consider to be your **main job**. What did you do all day in this job?

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4. In your main job, did you:

ACTIVITY	YES	NO	DESCRIBE
Use machines, tools or equipment?			
Use technical knowledge or skills?			
Do any writing, complete reports, or similar duties?			
Supervise other people?			
Other (describe)			

5. In your main job, how many **hours a day** did you:

Walk ________

Stand ________

Sit ________

Climb ________

Stoop (bend down & forward at waist) ________

Kneel (bend legs to rest on knees) ________

Crouch (bend legs & back down & forward) ________

Crawl (move on both hands & knees) ________

Handle, grab or grasp big objects ________

Write, type or handle small objects ________

6. Check **heaviest weight** lifted.

Less than 10 lbs. ☐ 10 lbs. ☐ 20 lbs. ☐ 50 lbs. ☐ 100 lbs. or more ☐ other ________

7. Check weight **frequently lifted.** (from 1/3 to 2/3 of the day)

Less than 10 lbs. ☐ 10 lbs. ☐ 20 lbs. ☐ 50 lbs. ☐ 100 lbs. or more ☐ other ________

IMPORTANT !!!

In terms of your ability to work, please tell us what you were able to do before that you cannot do now because of your health problems.

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8. Use this space to provide any additional information that you want us to have about your health problems or your ability to work.

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PLEASE SIGN AND DATE THIS FORM AND RETURN IT TO YOUR DSS WORKER AS SOON AS POSSIBLE.

______________________________ ______________

Signature Date

VERY IMPORTANT !!!

In order to make a decision, we need to get information from the doctors, clinics and hospitals that have been treating you. **We cannot do this unless you give us your permission by signing the W-303A "Authorization to Release Information from Examining Physician" forms. Be sure to sign a release of information form for each doctor, clinic and hospital you have listed.** Ask your worker if you need more release forms.