



State of Connecticut
Department of Social Services

Medical Report
(For Medicaid Disability and SAGA Cash Benefits)

W-300
(Rev. 7/08)

Dear Medical Provider:

The individual named on page three has applied for assistance with the Department of Social Services. He or she has acknowledged physical and/or mental health problems that prevent employment. Please complete this form so that we may verify eligibility for Medicaid disability or State Administered General Assistance (SAGA) unemployability benefits. To qualify, the individual must have a severe mental or physical impairment, or a combination of impairments that will preclude employment for at least six months (SAGA) or twelve months (Medicaid).

Instructions for completing the form:

- Complete Section A., General Information. Complete other sections only if they are relevant to the conditions for which you are providing treatment.

Medical providers, please take note. If this individual is applying for the Medicaid for the Employed Disabled (MED) program, he or she may be eligible even if he or she is employed as long as there is a significant impairment that would normally be considered disabling. You will need to complete the form in full for an MED applicant.

This individual is applying for MED. Yes No

- Please provide 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.
- Please tell us how the patient's symptoms, including possible side effects of medication, affect his or her ability to perform activities of daily living and function in the workplace. Specifically, what can the patient no longer do as a result of his or her health problems?
- Please tell us about how the combined effect of multiple conditions impacts this patient's ability to work, if applicable.
- If this patient has chronic conditions that have deteriorated over time, please tell us how and over what period of time the condition has worsened. What is the prognosis for the future?
- If you know of other providers that are treating this patient, please let us know so that we may contact them.
- If you know of diagnostic tests that have been taken but you do not know the results, please let us know from whom the results may be obtained.
- Return the completed form to the DSS worker named on page 2 of this form. Please feel free to contact the worker if you have any questions.

Thank you for taking the time to provide information on behalf of your patient.

Patient Name: _____ DSS Client ID #: _____

Telephone #: _____ Date of Birth: _____

Gender: Male Female

Section A. General Information

1. For what condition(s) are you treating this patient?

Diagnoses: 1. _____ 2. _____ 3. _____

This is a new condition (Approximate date of onset: _____).

This is a pre-existing condition (Approximate date of onset: _____).

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 block on the last page of this form.

If yes, go on to the next question.

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

Less than 2 months

2 months or more, but less than 6 months

6 months or more

12 months or more

If you checked either that the patient will be unable to work "Less than 2 months" or "2 months or more, but less than 6 months", **stop**. Proceed to page 10 and complete the signature section.

4. Please tell us how the patient's diagnosis, symptoms and prognosis impact his or her ability to work. Consider the effects of medications the patient may be taking for these conditions.

5. If this condition has recently deteriorated, please explain.

2. The patient can lift:

Weight patient can lift	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	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 yes or no)

Hand	Simple Grasping?		Push and Pull Arm Controls?		Fine Manipulation?	
	Yes	No	Yes	No	Yes	No
Right						
Left						

5. The patient can use feet repetitively for pushing and pulling leg controls:

Foot	Yes	No	Comments
Right			
Left			

6. The patient is able to:

Activity	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?

Activity	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 and humidity				
Driving automotive equipment				
Exposure to dust and fumes				

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

Section D. Mental Status Information

Complete this section if this patient has mental health issues that affect his or 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 not a mental health clinician, you may skip question 5 unless you have access to this information.

1. Does this patient have mental health or substance abuse issues that impact his or her ability to work? Yes No Unknown

If you checked "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 or her ability to work. Consider the effects of medications that patient may be taking for this condition.

3. This disorder is: a single episode an exacerbation of a chronic 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-IF diagnosis, if you know:

Axis I _____ Axis II _____ Axis III _____ Axis IV _____
Axis V GAF score: current _____ highest level in past year _____

Section E. Mental Residual Functional Capacity Assessment

1. Understanding and Memory

Function	No Evidence of Limitation in this Category	Not Significantly Limited (can consistently and usefully perform)	Moderately Limited (capacity to perform the activity is diminished)	Markedly Limited (cannot usefully perform or sustain the activity)
Remember locations & work-like procedures				
Understand and remember very short, simple instructions				
Understand and remember detailed instructions				

2. Sustained Concentration and Persistence

Function	No Evidence of Limitation in this Category	Not Significantly Limited (can consistently and usefully perform)	Moderately Limited (capacity to perform the activity is diminished)	Markedly Limited (cannot usefully perform or sustain the activity)
Carry out very short, simple instructions				
Carry out detailed instructions				
Maintain attention and 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/workweek without interruptions from psychologically based symptoms. Perform at a consistent pace without an unreasonable number and length of rest periods				

3. Social Interaction

Function	No Evidence of Limitation in this Category	Not Significantly Limited (can consistently and usefully perform)	Moderately Limited (capacity to perform the activity is diminished)	Markedly Limited (cannot usefully perform or sustain the activity)
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 and cleanliness				

4. Adaptation

Function	No Evidence of Limitation in this Category	Not Significantly Limited (can consistently and usefully perform)	Moderately Limited (capacity to perform the activity is diminished)	Markedly Limited (cannot usefully perform or sustain the activity)
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 in-patient admissions within the last five (5) years. Please include both medical and mental health admissions.

Dates of Admission	Facility	Reason for Admission and Treatment Received

Section G. Outpatient Treatment

Please indicate outpatient treatments received within the last five (5) years. Please do not include routine office visits.

Treatment	Date(s)	Description/Comments
Rehabilitation (PT,OT, speech, etc.)		
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	Is patient compliant with medications?	Please note any effects of this medication that impact this patient's ability to work. For example, significantly high dosage, severe side effects, etc.
	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> Unknown	
	<input type="checkbox"/> Yes <input type="checkbox"/> No <input type="checkbox"/> 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., Optometrist or, for diseases or injuries of the foot, a Podiatrist. If you are another type of medical professional, for example, 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., Optometrist or Podiatrist.

Name of person completing this form (print)	Title	Signature
Name of person co-signer, if required (print)	Title	Signature
Provider type (specialty)	Date	
Telephone Number	Fax Number	