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State of Connecticut
Department of Social Services

Medical Report for Person Who Needs Care

TO BE COMPLETED BY DSS WORKER

Client/Caregiver Name: ______________________________ Client ID#: ____________________

Patient Name: ____________________________ Relationship to Client/Caregiver: ________________

Dear Medical Provider:

Our client, listed above, told the Department of Social Services (DSS) that he or she cannot participate in DSS's employment program because he or she must be available to provide care for your patient, whose name is listed above.

Please complete this form if you are currently treating this patient above so that DSS may decide if our client should be exempted or excused temporarily from the program requirements.

If your patient does not currently have medical insurance and does not receive medical help from the Department of Social Services you must complete the W-513 form provided with this packet.

Medical Providers only – if you need assistance in completing this form call 1-860-424-5181.

TO BE COMPLETED BY MEDICAL PROVIDER

Patient Address:
____

1. What is the diagnosis for the patient? ____
   (Enter written diagnosis only – do not use diagnosis or ICD 9/10 codes)

   ____

   ____

2. Does the patient's need for care prevent the caregiver from working?

   ☐ No, the caregiver can work full time.

   If NO, stop here and skip to the signature instructions on page 4.

   ☐ Yes, ☐ the caregiver cannot work ☐ the caregiver can only work part-time

   If **YES**, please **complete** the rest of this form based upon your knowledge of your client's situation, and return it to the Department of Social Services within **14** days of receipt.

3. Does the patient need care on a substantially continuous basis? ☐ No ☐ Yes

   If yes, please describe the needed care:

   ____

   ____

   ____

4. Does the patient need care on an unpredictable basis? ☐ No ☐ Yes

   If yes, what care is needed and approximately how frequently is it needed?

   ____

   ____

   ____

5. Are there any in-home or community based services in place now? ☐ No ☐ Yes

   If yes, please describe them:

   ____

   ____

   ____

6. Are any other services needed? ☐ No ☐ Yes

   If yes, please describe them:

   ____

   ____

   ____

7. Is there any other person, either in the household or a service provider, who can perform the care?

   ☐ No ☐ Yes

   Please explain your answer:

   ____

   ____

   ____

8. Can the patient be left on his or her own for a period of time? For example, if the patient is a child, can the caregiver work while the child is in school? If the patient is an adult, can the caregiver leave the patient at home with all necessities within reach? ☐ No ☐ Yes

   Please explain your answer:

   ___

   ___

   ___

9. Can the patient attend day care or another out-of-home program on a predictable schedule?
   ☐ No ☐ Yes

   Please explain your answer:

   ___

   ___

   ___

10. If the caregiver is not available for work, how long will he or she be unavailable?

    ☐ Permanently ☐ Temporarily, can be available for work on ______________________________

11. Please give us information about the patient's household, if known. Specifically, is there anyone in the home who could provide assistance to the patient? Also, please feel free to provide us with any other supporting documentation to help us reach our decision.

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Signature Instructions for Medical Provider

Thank you for taking the time to complete this form on behalf of your patient. Please print (or stamp) your name **and** sign below. We cannot accept the completed form without your signature. This form may be signed by a licensed medical provider whose scope of practice, as defined by the Connecticut General Statutes, permits him or her to diagnose and treat the conditions for which this form is being completed. A licensed master social worker may complete this form relative to mental health disorders, but the co-signature of a supervising physician, advanced practice registered nurse, psychologist, professional counselor or licensed clinical social worker is required.

Your Name (Please Print)	Title	Signature
Provider Type (M.D., P.A., etc.)	License Number	Date
Telephone Number	Fax Number	

For Additional Co-Signature (when required):

Name of Co-Signer (Please Print)	Title	Signature
Co-Signer Provider Type (M.D., P.A., etc.)	License Number	Date
Telephone Number	Fax Number	

Important Notice for Medical Provider

After completing this form please return directly to DSS. Use the envelope and cover sheet provided. Please be sure that the address is displayed in the window of the envelope and send to:

DSS Scanning Center
PO Box 1320
Manchester, Ct. 06045-9968

Persons who are deaf or hard of hearing and have a TTD/TTY device can contact DSS at 1-800-842-4524
Persons who are blind or visually impaired can contact DSS at 1-860-424-5040.