W-1461
(Rev. 10/15)

State of Connecticut
Department of Social Services

Employment Services Medical Exemption Report

TO BE COMPLETED BY DSS WORKER

Patient Name: _____ Client ID# _____

Dear Medical Provider;

Your patient, whose name is listed above, told us that he or she has a medical condition that keeps him or her from participating in our employment programs.

Please complete this form if you are currently treating this patient for any physical or mental health conditions so that DSS may decide if the patient 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

1. Does this person's condition prevent him or her from working?

☐ No **If NO, stop here. Skip to the signature instructions on page 3 of this form.**

☐ Yes Diagnosis/Diagnoses: _____
(Enter written diagnosis only - do not use diagnosis or ICD 9/10 codes

_____

_____

The inability to work is expected to last (check one):

☐ Less than 30 days ☐ between 30 days and 3 months

☐ 3 months or more ☐ 6 months or more

On what date will this person be able to return to work? _____

On what date did the inability to work begin? _____

If you checked "Less than 30 days," STOP. Skip to the signature instructions on page 3. Otherwise, please complete the remainder of the form.

2. Is this person able to work on a part-time basis?

   ☐ Yes for _____ hours/week ☐ No

   Have you submitted a report for a Social-Security disability or SSI claim for this person within the last year? ☐ Yes ☐ No

B. Medical Information

1. When did you begin to see this person? _____
   Date
2. When was this person's most recent examination? _____
   Date
3. How often have you seen this person? _____ times in the past _____
   Number of visits Years or months
4. Is there a current problem with substance abuse? ☐ Yes ☐ No
5. Please identify this person's incapacitating symptom(s) and/or impairment(s) and explain how they prevent him or her from working. _____

   _____

   _____
6. How long has this person suffered from the condition(s)? _____
7. Are there any other symptoms or impairments affecting this person? _____

   _____

   _____
8. What is the prognosis for this person? Please explain, paying special attention to issues such as the way the condition limits the person's ability to work either full or part time, and whether the person could be employed full or part time with certain accommodations.

   _____

   _____

   _____

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 1-800-842-4525.
Persons who are blind or visually impaired can contact DSS at 1-860-454-5040.