W-300SA
(Rev 12/19)

State of Connecticut
Department of Social Services

**Medical Report**
**(For SAGA Cash Benefits)**

Dear Medical Provider:

The patient named on page 3 has applied for assistance with the Department of Social Services (DSS). He or she has acknowledged physical and/or mental health problems that prevent employment. Please complete the questions on this form in the space provided so we can decide whether he or she is eligible for State Administered General Assistance (SAGA) unemployability benefits. To qualify, the patient must have a severe mental or physical impairment, or a combination of impairments, that will preclude employment for at least 6 months.

In addition to completing these questions, please provide objective medical evidence, including copies of any diagnostic test results, pertaining to the diagnosed condition(s). **We cannot grant benefits without this objective medical evidence.** 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. A form W-303A, "Permission to Share Medical Information," was provided to the patient to sign so that you may release his or her medical information, but you may use your own authorization form if you prefer.

Please return the completed form to: Colonial Cooperative Care
Box 849
Norwich, CT 06360-9903

Phone: 860-885-0630
Fax: 860-885-0631

To bill DSS for your services, refer to the instructions on form W-513, "Request for Medical Payment," which was also provided to your patient.

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

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Patient Name: _____ DSS Client #:_____

**SECTION A. GENERAL INFORMATION**

1. What conditions have you diagnosed with respect to this patient? Please include physical and psychological conditions. For each diagnosed condition, please provide the 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 section on page 10 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, but less than 12 months ☐ 12 months or more

   **If you answered "Less than 2 months" or "2 months or more, but less than 6 months," <u>stop</u>.** Proceed to page 10 and complete the signature section. If you checked answered "6 months or more, but less than 12 months" or "12 months or more," **<u>continue</u>**.

4. How long have you been treating this patient? How frequently have you seen this patient during this time?

5. List the patient's symptoms, including pain, dizziness, fatigue, etc.:

   5.a. If your patient experiences pain, characterize the nature, location, frequency, precipitating factors and severity of this pain:



6. Please summarize the clinical findings and objective signs that support each diagnosis you listed above:

7. Describe the patient's response to treatment, including any side effects of medication, that may have a negative impact on his or her ability to work, such as drowsiness, dizziness, nausea, etc.:

8. What is the patient's prognosis?

9. Do emotional factors contribute to the severity of your patient's symptoms and functional limitations? ☐ Yes ☐ No

   9.a. If yes, please explain and describe how these emotional factors impact the patient's ability to work:

10. Does the patient have a problem with substance abuse? ☐ Yes ☐ No

    10.a. If yes, is the patient actively engaged in substance abuse treatment? ☐ Yes ☐ No

11. For each diagnosed psychological condition identified in question 1, please list the condition and indicate whether the patient is experiencing a single episode or an exacerbation of a chronic illness (if no psychological condition has been diagnosed, go directly to question 12):

11.a. If the psychological condition is recurrent, is there a cyclical pattern? ☐ Yes ☐ No
If yes, describe the frequency of this pattern:

12. Please describe any other limitations (such as limited vision, difficulty hearing, or the need to avoid temperature extremes, wetness, humidity, noise, dust, fumes, gases or other hazards) that affect the patient's ability to work at a regular job on a sustained basis:

13. Are the patient's impairments, as demonstrated by signs, clinical findings and laboratory or test results, reasonably consistent with the symptoms and functional limitations described on this form? ☐ Yes ☐ No

13.a. If no, please explain the discrepancy:

**SECTION B. PHYSICAL CAPACITIES EVALUATION**

1. In terms of the patient's ability to perform during an 8-hour work day with normal breaks, the patient can:

| Activity | Never | 1 Hour | 2 Hours | 3 Hours | 4 Hours | 5 Hours | 6 Hours + |
|---|---|---|---|---|---|---|---|
| Sit | | | | | | | |
| Stand | | | | | | | |
| Walk | | | | | | | |

Patient Name: _____ DSS Client #:_____

2. The patient can lift and carry:

| Weight patient can lift | Never | Rarely (1-5% of work day) | Occasionally (1-33% of work day) | Frequently (34-66% of work day) | Continuously (67-100% of work day) |
|---|---|---|---|---|---|
| 1-10 lbs. | | | | | |
| 11-20 lbs. | | | | | |
| 21-49 lbs. | | | | | |
| 50 lbs. or more | | | | | |

3. Does the patient have significant limitations with reaching, grasping, handling or fingering objects?
☐ Yes ☐ No

If yes, indicate the percentage of time during an 8-hour work day that your patient can use his or her hands, fingers, and arms for the following activities:

| Hand/Arm | Grasping, turning, and twisting objects | Fine manipulation of objects using the fingers | Reaching with arms in front of body | Reaching with arms overhead |
|---|---|---|---|---|
| Right | _____% | _____% | _____% | _____% |
| Left | _____% | _____% | _____% | _____% |

4. The patient is able to:

| Activity | Never | Rarely (1-5% of work day) | Occasionally (6-33% of work day) | Frequently (34-66% of work day) | Continuously (67-100% of work day) |
|---|---|---|---|---|---|
| Stoop / Bend | | | | | |
| Crouch / Squat | | | | | |
| Twist | | | | | |
| Climb Stairs | | | | | |
| Climb Ladders | | | | | |

Patient Name: _____ DSS Client #:_____

5. To what extent can the patient be involved in the following activities?

| Activity | Never | Rarely (1-5% of work day) | Occasionally (1-33% of work day) | Frequently (34-66% of work day) | Continuously (67-100% of work day) |
|---|---|---|---|---|---|
| Unprotected heights | | | | | |
| Being around moving machinery | | | | | |
| Exposure to marked changes in temperature/ humidity | | | | | |
| Driving automotive equipment | | | | | |
| Exposure to dust and fumes | | | | | |

6. Does the patient require the use of assistive equipment, such as a cane or walker, when standing or walking? ☐ Yes ☐ No

   If yes, what symptoms require the use of this assistive equipment?

   ☐ Imbalance ☐ Pain ☐ Weakness ☐ Insecurity ☐ Dizziness ☐ Other: _____

## SECTION C. MENTAL RESIDUAL FUNCTIONAL CAPACITY ASSESSMENT

1. During what percentage of a typical work day are your patient's symptoms likely to be so severe that they interfere with attention and concentration needed to perform even simple work tasks?

   ☐ 0% ☐ 1-5% ☐ 6-10% ☐ 11-15% ☐ 16-20% ☐ 21-25% or more ☐ More than 25%

2. To what degree can the patient tolerate work stress?

   ☐ Incapable of tolerating even "low stress" ☐ Capable of tolerating only low stress

   ☐ Capable of tolerating moderate (normal) stress ☐ Capable of tolerating high stress

3. In each table that follows, please place a mark in the box that best describes how the patient's conditions impact the indicated function. "Not significantly limited" means the patient can consistently and usefully perform the function. "Moderately limited" means the patient's capacity to perform the function is diminished. "Markedly limited" means the patient cannot usefully perform or sustain performance of the function.

**Memory and understanding**

| Function | No Limitation | Not Significantly Limited | Moderately Limited | Markedly Limited |
|---|---|---|---|---|
| Remember locations & work-like procedures | | | | |
| Understand and remember very short, simple instructions | | | | |
| Understand and remember detailed instructions | | | | |

**Social interaction**

| Function | No Limitation | Not Significantly Limited | Moderately Limited | Markedly Limited |
|---|---|---|---|---|
| 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 | | | | |

Patient Name: _____ DSS Client #:_____

**Sustained concentration and persistence:**

| Function | No Limitation | Not Significantly Limited | Moderately Limited | Markedly Limited |
|---|---|---|---|---|
| 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 work day/workweek without interruptions from symptoms (i.e., able to perform at a consistent pace without an unreasonable number and length of rest periods) | | | | |

**Adaptation**

| Function | No Limitation | Not Significantly Limited | Moderately Limited | Markedly Limited |
|---|---|---|---|---|
| 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 | | | | |

**<u>Please complete and sign section on reverse.</u>**

Patient Name: _____ DSS Client #:_____

## 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. We cannot accept the completed form without your signature. This form may be signed by any licensed medical provider whose scope of practice, as set forth in 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 with respect 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.

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