



W-303
(Rev. 2/08)

State of Connecticut
Department of Social Services

Client Supplement for Medical Information

You asked for help from the Department of Social Services (DSS). You asked for this help because you have health problems and cannot work. In order for the department to decide that we can give you help because of your health problems, you must give us medical proof of your condition.

Your worker will give you the forms we need to decide if you can receive help. The department will look at the information we get from your doctor(s) and from you to make that decision. If you need help getting any forms or information sent to DSS from your doctors, talk to your worker. Your worker will help you to get the information that you need and get the information returned to us.

- Give form W-300, "Medical Report", to your doctor to fill out. If you have more than one doctor, ask your worker for more forms. Give one to each of your doctors. If you need help making an appointment with your doctor because of your health problems, let your worker know. He or she can help you make the appointment.
- This form, W-303 "Client Supplement for Medical Information", is for you to fill out. Use it to tell us how your health problems keep you from working. **This is your chance to tell us anything you want us to know about your health problems and how they affect you. Be sure to fill this form out completely.** If you need help filling out this form, tell your worker. He or she will help you fill it out or refer you to someone who can help you.
- We may give you a form W-513, "Request for Medical Payment". We will give this to you if you do not already get medical help from DSS. The doctor needs the W-513 so that he or she can bill the department for his or her services.
- Sign a form W-303A, "Permission to Share Medical Information" for each of your doctors.

Once we receive the medical information, the department will review it and tell you our decision. If we need more information, we will let you know.

If you do not agree with any decision we make, you can ask for a fair hearing.

If you disagree with a medical decision that we make for the SAGA program, you can also ask for reconsideration. Your worker will be able to give you the W-1060 "Reconsideration Petition" form you need.

This information is available in alternate formats. Phone (800) 842-1508 or TDD/TTY (800) 842-4524.

Part A. Tell us about yourself.

Name : _____

DSS Client ID : _____

Address: _____

SSN: _____

Date of Birth: _____

Phone: _____

Sex: Male Female

1. Are you right-handed or left-handed? Right Left
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 with friends or family Live alone Other _____
4. What is your living arrangement? (check one)
 Home or apartment Group home or halfway house
 Nursing Home Other _____
 Homeless If homeless, do you live in an emergency shelter? Yes No
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 Use Public Transportation Walk Dial-a-Ride
 Ride with friends or relatives
 Do you transfer from one bus/train/cab to another? Yes No
 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 contacts or glasses? Yes No
 Do you have problems seeing even with glasses or contacts? Yes No
10. Do you have problems hearing? Yes No
 If yes, do you wear a hearing aid? Yes No

Part B. Tell us about your health.

1. Tell us which doctors and clinics you are seeing for these health problems. Attach additional sheets if necessary.

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: _____

2. 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.

Name of Hospital	Address of Hospital (city and state)	Reason for hospital visit	What date(s) were your visits?
			From: _____ To: _____
			From: _____ To: _____
			From: _____ To: _____
			From: _____ To: _____

3. Have your health problems become worse lately? Yes No If yes, please explain.

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

5. Tell us how these health problems keep you from working. _____

6. Put a check in front of every statement that is true.

- | | |
|--|--|
| <input type="checkbox"/> I feel sad a lot of the time. | <input type="checkbox"/> I have much more energy than usual |
| <input type="checkbox"/> I have problems sleeping.
(sleep too much or too little). I wake up at night. | <input type="checkbox"/> I have problems concentrating or thinking |
| <input type="checkbox"/> I am not interested in activities I usually like. | <input type="checkbox"/> I have panic attacks |
| <input type="checkbox"/> I feel guilty or worthless | <input type="checkbox"/> I hear voices when no one is there |
| <input type="checkbox"/> My appetite has changed (I eat too much or too little) | <input type="checkbox"/> I see things that others don't see |
| <input type="checkbox"/> I think people are trying to hurt me in some way | <input type="checkbox"/> I have no energy |
| <input type="checkbox"/> I feel nervous or anxious (worried) all the time | <input type="checkbox"/> I think about hurting myself |
| <input type="checkbox"/> I have problems staying awake during the day. | <input type="checkbox"/> I think about hurting others |
| <input type="checkbox"/> I have certain routines (for example, washing hands) that I must do over and over | |

7. Do you drink alcohol? Yes No
If yes, how much? _____

How often? _____

8. Do you use drugs? Yes No
If yes, what kind? _____

How often? _____

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

Part C. Tell us about what you can do.

1. Tell us how much of the time you can do these activities? Check "Often", "Sometimes", or "Never" for each activity.

Often	Sometimes	Never		Often	Sometimes	Never	
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Sitting	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Lifting
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Standing	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Grasping
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Walking	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pushing
<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Bending	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pulling

2. If you can you do any of these, put a check in the box that says, "Can Do". If you need help to do it, check the box that says, "Need Help".

Can Do	Need Help		Can Do	Need Help	
<input type="checkbox"/>	<input type="checkbox"/>	Shop for food	<input type="checkbox"/>	<input type="checkbox"/>	Exercise
<input type="checkbox"/>	<input type="checkbox"/>	Plan Meals	<input type="checkbox"/>	<input type="checkbox"/>	Household Chores
<input type="checkbox"/>	<input type="checkbox"/>	Cook	<input type="checkbox"/>	<input type="checkbox"/>	Count change
<input type="checkbox"/>	<input type="checkbox"/>	Read	<input type="checkbox"/>	<input type="checkbox"/>	Talk on the phone
<input type="checkbox"/>	<input type="checkbox"/>	Watch TV	<input type="checkbox"/>	<input type="checkbox"/>	Do arts & crafts
<input type="checkbox"/>	<input type="checkbox"/>	Play sports	<input type="checkbox"/>	<input type="checkbox"/>	Paint or draw
<input type="checkbox"/>	<input type="checkbox"/>	Listen to music	<input type="checkbox"/>	<input type="checkbox"/>	Knit or crochet
<input type="checkbox"/>	<input type="checkbox"/>	Ride a bicycle	<input type="checkbox"/>	<input type="checkbox"/>	Sew
<input type="checkbox"/>	<input type="checkbox"/>	Visit people	<input type="checkbox"/>	<input type="checkbox"/>	Walk
<input type="checkbox"/>	<input type="checkbox"/>	Use the computer	<input type="checkbox"/>	<input type="checkbox"/>	Jog (run)
<input type="checkbox"/>	<input type="checkbox"/>	Play video games			

3. If you have problems doing an activity, check "Some Problems". If you have a lot of problems doing it check "Many Problems".

Some Problems	Many Problems	
<input type="checkbox"/>	<input type="checkbox"/>	Paying attention
<input type="checkbox"/>	<input type="checkbox"/>	Learning new things
<input type="checkbox"/>	<input type="checkbox"/>	Remembering
<input type="checkbox"/>	<input type="checkbox"/>	Organizing
<input type="checkbox"/>	<input type="checkbox"/>	Listening
<input type="checkbox"/>	<input type="checkbox"/>	Reading
<input type="checkbox"/>	<input type="checkbox"/>	Going outside
<input type="checkbox"/>	<input type="checkbox"/>	Getting along with others

Please tell us about the problems you are having in each area

Part D. Tell us about any education and training you have had.

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
<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/>

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. _____

Part E. Tell us about what you have done for work.

1. Please answer the following questions about your work history.

- a. Have you ever worked outside the home? Yes No
- b. If you have never worked please explain why. _____
- c. Are you working now? Yes No
- d. If no, when did you stop working? Month _____ Year _____
- e. When did your health problems begin? Month _____ Year _____
- f. Did you work at any time after your health problems began? Yes No
- g. 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 Mo/Yr	To Mo/Yr			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?

4. Check off and describe the things that you did in your main job.

- Use machines, tools or equipment? _____
- Use technical knowledge or skills? _____
- Do any writing, complete reports, or similar duties? _____
- Supervise other people? _____
- Other (describe) _____

5. Tell us how many hours a day you did any of the following activities.

_____	Walk	_____	Kneel (bend legs to rest on knees)
_____	Stand	_____	Crouch (bend legs & back, down & forward)
_____	Sit	_____	Crawl (move on both hands & knees)
_____	Climb	_____	Handle, grab or grasp big objects
_____	Stoop (bend down & forward at waist)	_____	Write, type or handle small objects

6. Check heaviest weight that you lifted.

less than 10 lbs. 10 lbs. 20 lbs. 50 lbs. 100 lbs. or more Other _____

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

less than 10 lbs. 10 lbs. 20 lbs. 50 lbs. 100 lbs. or more Other _____

8. Please tell us what you could do at work before that you cannot do now because of your health problems.

9. Use this space to give us any additional information that you want us to have about your health problems or your ability to work. **This is your chance to tell us everything you want us to know about your health problems.**

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.