CONNECTICUT Labor

Form UC-16Q: Substance Abuse Information Sheet (Request for Certification by Substance Abuse Treatment Professional)

State of Connecticut Department of Labor, Employment Securing Adjudications

Print a PDF Version of This Form

You can access the PDF version of this form by clicking the link below. When you click this link, the PDF will open in a new tab in your browser:

Form UC-16Q: Substance Abuse Information Sheet (Request for Certification by Substance Abuse Treatment Professional) >

To print the PDF from your browser, click on the Print symbol: 

Name

First Name

Last Name

Social Security Number

Enter the 9 digits of your Social Security Number (SSN).

Section 31-235 of the Connecticut Unemployment Compensation Law provides, in part, that an individual must be able and available for full-time work in order to be eligible for benefits.

For those individuals whose job separations are attributable to alcohol or substance dependency, information pertaining to the individual's ability to work as well as substantial steps the individual has made towards recovery must be obtained. Individuals with addictions to alcohol or drugs cannot be found able to work if they continue to engage in active drug or alcohol abuse. Benefits are reserved for those who have acknowledged their disease and are making good faith efforts toward recovery.

The information requested on this form regarding the individual's recovery efforts is essential for making a proper determination of eligibility for benefits. It is the responsibility of the individual to provide this information to the Adjudications Specialist by having the form completed.

In instances where there is more than one person who can provide information regarding the individual's recovery efforts, the form may be sent to all pertinent parties.

This form is to be completed by a Substance Abuse Treatment Professional such as a counselor, therapist, doctor or health professional with whom the individual is seeking treatment when the individual has indicated that he has completed a rehabilitation program or is currently receiving formal treatment.

The form requests detailed information regarding the type of treatment, frequency and duration. If the individual is in a "day" or "out patient" program, it is necessary to indicate whether the hours of the treatment are flexible and could be changed if necessary to accommodate a job search and subsequent employment. If the individual has completed treatment, it is critical to indicate whether the treatment was successfully completed and to attach a discharge summary, if available. In addition, the health professional must provide details of the individual's on-going treatment and recommended aftercare to show that the individual is engaged in ongoing recovery efforts.

Certification

Claimant Name

First Name

Last Name

Claimant's Social Security Number

Enter the 9 digits of the claimant's Social Security Number (SSN).

I hereby authorize the Substance Abuse Treatment Professional to release to the Department of Labor the information requested on this form. The information may be used to determine my eligibility for unemployment compensation benefits.

Claimant's Signature

Date

Month Day Year

Phone Number

Area Code Phone Number

Return to:

Request for Certification by Substance Abuse Treatment Professional

Name of Treatment Facility

Treatment Facility Address

Street Address

Street Address Line 2

City

State / Province

Postal / Zip Code

Please use the space below to describe the type of treatment the individual received.

Enter your response in the space above.

Did the individual receive inpatient treatment or outpatient treatment?

- Inpatient
- Outpatient

Please use the space below to enter the number of days per week the individual received treatment.

Please use the space below to enter the number of hours per week the individual received treatment.

Treatment Start Time

Enter start time above.

Treatment End Time:

Enter end time above.

Treatment Start Date

Month Day Year

Is the individual currently in treatment?

- Yes
- No

Did the individual successfully complete treatment?

- Yes
- No

If the individual successfully completed treatment, please enter the date on which they completed treatment.

Month Day Year

Is the individual currently in an outpatient program?

- Yes
- No

If the individual is currently in an outpatient program, are flexible treatment hours available so as to allow for work search and employment?

- Yes
- No

If (1) the individual is currently in an outpatient program, and (2) flexible treatment hours are available so as to allow for work search and employment, please use the space below to describe in what way could the treatment hours be changed.

Enter your response in the space above.

Please use the space below to describe the ongoing rehabilitation the individual is receiving. Specifically, provide details as to the frequency and nature of the individual's recovery efforts (e.g., NA, AA, counseling).

Enter your response in the space above.

Please use the space below to describe what after-care program and counseling have been recommended. Please include detailed steps the claimant must follow to maintain sobriety and to become gainfully employed, discharge summary or treatment plan, if available.

Enter your response in the space above.

In your professional opinion, does the individual have any barriers which would prevent him/her from currently being able and available to work on a full-time basis?

- ◯ Yes
- ◯ No

If (in your professional opinion) the individual does have barriers which would prevent him/her from currently being able and available to work on a full time basis, please use the space below to explain.

Enter your response in the space above.

Please use the space below to enter any comments you have regarding the individual's recovery efforts.

Substance Abuse Treatment Professional Signature

Substance Abuse Treatment Professional's Title

Substance Abuse Treatment Professional Address

Street Address

Street Address Line 2

City

State / Province

Postal / Zip Code

Substance Abuse Treatment Professional's Signature

Date

Month Day Year

Substance Abuse Treatment Professional Phone Number

Area Code Phone Number

CONNECTICUT