State of Connecticut
Department of Social Services

W-303
(Rev. 2/08)

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 you 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.

- ☐ I feel sad a lot of the time.
- ☐ I have problems sleeping. (sleep too much or too little). I wake up at night.
- ☐ I am not interested in activities I usually like.
- ☐ I feel guilty or worthless
- ☐ My appetite has changed (I eat too much or too little)
- ☐ I think people are trying to hurt me in some way
- ☐ I feel nervous or anxious (worried) all the time
- ☐ I have problems staying awake during the day.
- ☐ I have much more energy than usual
- ☐ I have problems concentrating or thinking
- ☐ I have panic attacks
- ☐ I hear voices when no one is there
- ☐ I see things that others don't see
- ☐ I have no energy
- ☐ I think about hurting myself
- ☐ I think about hurting others
- ☐ 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 n 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	
☐	☐	☐	Sitting	☐	☐	☐	Lifting
☐	☐	☐	Standing	☐	☐	☐	Grasping
☐	☐	☐	Walking	☐	☐	☐	Pushing
☐	☐	☐	Bending	☐	☐	☐	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	
☐	☐	Shop for food	☐	☐	Exercise
☐	☐	Plan Meals	☐	☐	Household Chores
☐	☐	Cook	☐	☐	Count change
☐	☐	Read	☐	☐	Talk on the phone
☐	☐	Watch TV	☐	☐	Do arts & crafts
☐	☐	Play sports	☐	☐	Paint or draw
☐	☐	Listen to music	☐	☐	Knit or crochet
☐	☐	Ride a bicycle	☐	☐	Sew
☐	☐	Visit people	☐	☐	Walk
☐	☐	Use the computer	☐	☐	Jog (run)
☐	☐	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		Please tell us about the problems you are having in each area
☐	☐	Paying attention	_____
☐	☐	Learning new things	_____
☐	☐	Remembering	_____
☐	☐	Organizing	_____
☐	☐	Listening	_____
☐	☐	Reading	_____
☐	☐	Going outside	_____
☐	☐	Getting along with others	_____

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
☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐

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 <u>each</u> doctor, clinic and hospital you have listed. Ask your worker if you need more release forms.