State of Connecticut
Department of Social Services

W-300A
(Rev. 7/08)

# Medical Statement

The individual listed below has applied for help with the Department of Social Services. This person has told us that he or she has a medical or psychiatric condition that will not allow him or her to work for at least 30 days. Your answers to the questions on this form will help us to determine the individual's employability status and/or disability status for our programs. If the patient is currently under your care, the report may be prepared from your existing records.

Client Name: _____ Social Security Number: _____

Date of Birth: _____ Client ID Number: _____

Client's statement of his/her medical condition: _____

_____

**Please answer the following based on your records and knowledge of the patient.**

1. Does the patient have a significant medical condition that prevents him or her from working?

   ☐ Yes ☐ No If yes, what is the diagnosis? _____

2. How much longer is this condition expected to last? (please check one)

   ☐ Less than 30 days ☐ More than 2 months but less than 6 months

   ☐ More than 30 days but less than 2 months ☐ 6 months or more

   When do you think the patient will be able to return to work? _____
   Date

3. Does the patient have a mental health or substance abuse problem?

   ☐ Yes ☐ No If yes, which one? _____

**Signature Instructions**

Please print (or stamp) your name and sign below. This form may be signed by an M.D., D.O., Ph.D., Optometrist or, for diseases or injuries of the foot, a Podiatrist. If you are another type of medical professional, for example, a nurse practitioner or physician's assistant, you may complete this form but it must be co-signed by an M.D., D.O., Ph.D., Optometrist or Podiatrist.

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

**<u>Important</u> - See Reverse for Mailing and Billing Instructions**

**Please return this form to:**

DSS Worker: _____

Address: _____

Telephone: _____ Fax No. _____

**Release of Information**

Name of Doctor, Clinic or Hospital _____

I hereby authorize the medical professional named above to release or disclose to the state of Connecticut, Department of Social Services, the following information:

All medical records or other information regarding my treatment, hospitalization and/or outpatient care for my condition including: psychological and psychiatric impairments, drug and alcohol abuse, sickle cell anemia, AIDS, sexually transmitted diseases, tests for HIV, and how my health problems affect my activities of daily living and my ability to work.

I authorize a photocopy or fax of this release to be accepted with the same authenticity as the original. I understand that I may withdraw this authorization in writing at any time, except for action already taken. Unless I have cancelled it, this authorization will expire when a determination is made with regard to my eligibility for Medicaid disability and/or SAGA unemployability benefits.

_____ _____

Signature Date

**Billing and Payment Instructions**

Please access the Automated Eligibility Verification System (AEVS) for confirmation of eligibility.

If SAGA eligibility is confirmed, you will need to be enrolled as a CHNCT provider in order to be paid. Please call CHNCT Provider Relations at (800) 440-5071 to enroll and for billing instructions.

Submit claims for all other eligibility categories to EDS, P.O. Box 2941, Hartford, Ct. 06104. Submit your claim on a CMS 1500 form.

Important: If client is not currently active with DSS, you must attach form W-513, “Examination Request for Medical Eligibility Determination” to the CMS 1500 in order to be paid.