State of Connecticut
Department of Social Services

W-1210
(New 7/16)

SNAP ABAWD Work Requirement Medical Report

Patient/Participant Name _____

Client ID# _____

Address
_____

The patient listed above requests verification of their medical condition and/or participation in your program. Please complete this form and sign it below. You or the patient should mail the completed form to the following State of Connecticut Department of Social Services (DSS) address:

DSS ConneCT Scanning Center
P.O. Box 1320
Manchester CT, 06045-1320

Please answer **one** or **more** of the following questions and then complete the signature section below.

1) Is this patient pregnant? □ yes □ no □ unknown.

If **yes**, what is the due date? ___/____/_____

2) Is this patient addicted to drugs or alcohol? □ yes □ no □ unknown

3) Is the patient a participant in a vocational rehabilitation program, a mental health counseling program, or a drug or alcohol treatment or counseling program?

___yes ___no.

If yes, when did patient's participation in the program begin?
_____

4) Does this patient have a temporary or permanent mental and/or physical illness or disability that prevents him or her from working at least 20 hours per week on average? __yes ___no

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Signature Instructions for Medical Provider

Thank you for taking the time to complete this form on behalf of your patient. Please print (or stamp) your name **and** sign below. We cannot accept the completed form without your signature. This form may be signed by a licensed medical provider whose scope of practice, as defined by 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 relative 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. A certified alcohol or drug counselor may sign to verify that the patient is addicted to drugs or alcohol or enrolled in a drug or alcohol treatment or counseling program.

Your Name (Please Print) | Title | Signature

Provider Type (M.D., P.A., etc.) | License Number | Date

Telephone Number | Fax Number

For Additional Co-Signature (when required):

Name of Co-Signer (Please Print) | Title | Signature

Co-Signer Provider Type (M.D., P.A., etc.) | License Number | Date

Telephone Number | Fax Number

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Return this form to:

The DSS ConneCT Scanning Center

PO Box 1320

Manchester CT 06045-1320

Make sure that your client number ID is on every document that you send in.

In accordance with Federal civil rights law and U.S. Department of Agriculture (USDA) civil rights regulations and policies, the USDA, its Agencies, offices, and employees, and institutions participating in or administering USDA programs are prohibited from discriminating based on race, color, national origin, sex, religious creed, disability, age, political beliefs, or reprisal or retaliation for prior civil rights activity in any program or activity conducted or funded by USDA.

Persons with disabilities who require alternative means of communication for program information (e.g. Braille, large print, audiotape, American Sign Language, etc.), should contact the Agency (State or local) where they applied for benefits. Individuals who are deaf, hard of hearing or have speech disabilities may contact USDA through the Federal Relay Service at (800) 877-8339. Additionally, program information may be made available in languages other than English.

To file a program complaint of discrimination, complete the USDA Program Discrimination Complaint Form, (AD-3027) found online at: http://www.ascr.usda.gov/complaint_filing_cust.html, and at any USDA office, or write a letter addressed to USDA and provide in the letter all of the information requested in the form. To request a copy of the complaint form, call (866) 632-9992. Submit your completed form or letter to USDA by:

(1) mail:

U.S. Department of Agriculture
Office of the Assistant Secretary for Civil Rights
1400 Independence Avenue, SW
Washington, D.C. 20250-9410;

(2) fax: (202) 690-7442; or

(3) email: program.intake@usda.gov.

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You may also file discrimination complaints or request reasonable accommodations as follows:

You have the right to make a discrimination complaint if you think we have taken action against you because of your race, color, religion, sex, gender identity or expression, marital status, age, national origin, ancestry, political beliefs, sexual orientation, intellectual disability, mental disability, learning disability, or physical disability, including, but not limited to, blindness.
An individual with a disability may request and receive a reasonable accommodation or special help from the Department of Social Services when it is necessary to allow the individual to have an equal and meaningful opportunity to participate in programs administered by the Department.
If you asked for an accommodation or special help and we refused to provide it, you may make a complaint to the Department's Affirmative Action Division Director or any of the agencies listed below:

Commissioner of Social Services
Attention: Affirmative Action Division Director/ADA Coordinator
55 Farmington Avenue
Hartford, CT 06106-5033
Telephone: 1-860-424-5040, toll free: 1-800-842-1508, TDD: 1-800-842-4524
Fax: 1-860-424-4948

Connecticut Commission on Human Rights and Opportunities
55 Farmington Avenue
Hartford, CT 06106
Telephone: 1-860-541-3400, toll free: 1-800-477-5737, TDD: 1-860-541-3459
Fax: 1-860-246-5265
Web: http://www.ct.gov/chro/site/default.asp

This institution is an equal opportunity provider.

Persons who are deaf or hard of hearing and have a TTD/TTY device can contact DSS at 1-800-842-4524. Persons, who are blind or visually impaired, can contact DSS at 1-860-424-5040.