CHILD SUPPORT AGENCY

Thomas M. Fandry, Administrator

PHONE: (608) 355-3238
FAX: (608) 355 -3239
TDD: (608) 355-3490

MEDICAL DOCUMENTATION REQUIREMENTS FOR CSA

If a medical or health condition has rendered you unable to do any type of work and a doctor has made that determination, you are required to provide the following documentation to the Agency, in writing, at the address below. **IT IS YOUR RESPONSIBILITY TO OBTAIN THE INFORMATION FROM YOUR DOCTOR OR HEALTH CARE PROVIDER AND SEND IT IN A TIMELY MANNER TO THE AGENCY.** The Agency will not obtain it for you.

1) An original, signed, written medical excuse from your doctor stating: the nature of your illness/condition, the length of time you are unable to work, how your condition effects your ability to work, the anticipated length of time you will be incapacitated, the treatment you are receiving for the condition, and when you will be reevaluated. This information must be updated MONTHLY, unless otherwise ordered by the Court, unless you are advised otherwise in writing by the Agency, or until you are released to return to work, even if you are released with work restrictions.

2) If you apply for Social Security Disability, a copy of all information regarding your condition that you supplied to the Social Security Administration. You must update the Agency, in writing, of the status of your claim and also upon the receipt of any benefits award, including past benefits.

3) If you apply for Worker's Compensation, the name of the insurer and employer involved in the claim, copies of all medical documentation regarding your ability to work, including functional capacity reports and vocation reports. You must update the Agency, in writing, of the status of your claim, receipt of any worker's compensation, including lump sum payments or temporary disability payments.

4) The Agency has "Ability to Work" forms which are designed to assist your doctor in providing the information the Agency requires to determine your work status. You can get the forms from the Agency. The form is not required, and supplemental information may be required by the Agency if your medical condition will leave you unable to work for longer than 8 weeks.

5) Any and all information related to any form of monetary compensation you may be entitled to regarding your medical condition.

This list is intended to be a general guideline to parties whose ability to work is impacted by a medical condition or illness. It is not all inclusive and there may be specific additional requirements under your court order.

HISTORIC COURTHOUSE * 515 OAK STREET * BARABOO, WISCONSIN 53913

ABILITY TO WORK REPORT - SAUK COUNTY CSA

Patient Name: Diagnosis:
Date of Birth:
SSN: Date of injury/illness:

PLEASE SELECT **ONE** OF THE FOLLOWING OPTIONS:

1. ___ Patient is PERMANENTLY & TOTALLY DISABLED as of ____________________(date).

OR

2. ___ Patient is TEMPORARILY, TOTALLY DISABLED as of ______________________(date) through ______________________(date) **AND**

   a) On ______________________(date), Patient will be reevaluated.

   OR

   b) Patient has been referred to ______________________ for further treatment/opinion.
   Name / Address / City / State / Phone: ________________________________
   ____
   ____

OR

3. ___ Patient is PERMANENTLY, PARTIALLY DISABLED & has the following work restrictions as of ___________________________(date), as follows/attached:

   ____
   ____
   ____

OR

4. ___ Patient is TEMPORARILY, PARTIALLY DISABLED & has the following work restrictions as of _______________________(date), as follows/attached:

   ____
   ____ **AND**
   will be reevaluated on _____________________________(date) OR
   will be released to return to work without restrictions on ________________________(date).

Medical Provider's Signature (No Stamps): ________________________________Date:___________
Medical Provider's Printed or Stamped > Name / Address / City / State / Phone:

Sauk County Child Support Fax # 608-355-3239