CHILD SUPPORT AGENCY
St. Croix County Government Center
1101 Carmichael Road
Hudson, WI 54016
Phone: (715) 386-4691 Fax (715) 381-4410
website: http://www.sccwi.gov

Date: _____

IVD #: _____

Court Case: _____

MEDICAL DOCUMENTATION REQUIREMENTS FOR CSA

If a medical or health condition has rendered you unable to do any type of work or has limited your ability to work and pay child support and a doctor has made that determination, provide the following documentation to the Child Support Agency on or before _____.

1) **MEDICAL STATEMENT** from your doctor providing information as to 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.

   Attached is an *"Ability to Work"* form designed to assist your doctor in providing the information the Agency requires to determine your work status.

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. You are to provide to the Child Support Agency copies of any updates or information received from the Social Security Administration.

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.

4) **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.

Failure to provide the requested information may result in court action as it may be presumed that you are capable of working and paying your child support obligation.

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ABILITY TO WORK REPORT

Patient Name: _____ Date of Birth: _____

Date of injury/illness: _____

Diagnosis: _____

_____

Prognosis: _____

_____

PLEASE COMPLETE THE FORM BY SELECTING THE OPTION(S) THAT APPLY:

☐ Patient is PERMANENTLY & TOTALLY DISABLED as of _____(date)

☐ Patient is TEMPORARILY DISABLED and unable to work as of _____(date)

AND

☐ Will be reevaluated on _____(date)

OR

☐ Patient has been referred to _____for further treatment/opinion. Address / City / State / Phone:

_____

☐ Patient is TEMPORARILY or PARTIALLY DISABLED & has the following work restrictions as of _____(date) through _____(date)

as follows or attached:

_____

_____

AND ☐ Will be reevaluated on _____(date)

☐ Patient can work **with** restrictions as stated above as of _____(date)

☐ Patient is released to return to work **without** restrictions as of _____(date)

Medical Provider's Signature (No Stamps): _____ Date: _____

Medical Provider's Printed or Stamped Name: _____

Address: _____Phone: _____