

WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES
 ANNUAL MEDICAL EVALUATION

Participant Name:	_____	Date:	_____
Participant Address:	_____	Birthdate:	_____
	_____	SS#:	_____
	_____	Medicaid #:	_____
Participant e-Mail:	_____	Phone:	_____
Behavioral Health Center:	_____		
BHC Address:	_____	Phone:	_____
	_____	Fax:	_____
Physician:	_____		
Physician Address:	_____	Phone:	_____
	_____	Fax:	_____

DIAGNOSES

_____ MENTAL: List all cognitive, developmental, behavioral, emotional and/or psychiatric conditions.

_____ PHYSICAL: List all chronic and handicapping conditions, as well as current acute conditions.

MEDICAL NEEDS (Rx with amounts; valid for 1 year unless otherwise noted.)

_____ NURSING CARE (*specify*) _____

_____ PERSONAL CARE / HYGIENE _____

_____ THERAPY: _____

_____ SPEECH _____

_____ PHYSICAL _____

_____ OCCUPATIONAL _____

_____ OTHER (*specify*) _____

_____ EQUIPMENT / SUPPLIES: _____

_____ MOBILITY _____

_____ CONTINENCE _____

_____ FEEDING / NUTRITION _____

_____ OTHER (*specify*) _____

_____ OTHER (*specify*) _____

_____ _____

I certify that this patient's developmental disability and related health needs are as documented above, and the patient, but for the provision of home- and community-based waiver services, would require the level of care provided in an intermediate care facility for the mentally retarded* (ICF/MR).

_____	_____	_____
Date	Physician's Signature	License #

* An ICF/MR "means an institution (or distinct part of an institution) that – (1) Is primarily for the diagnosis, treatment, or rehabilitation of the mentally retarded or persons with related conditions; and (2) Provides, in a protected residential setting, ongoing evaluation, planning, 24-hour supervision, coordination, and integration of health or rehabilitative services to help each individual function at his greatest ability." (42 CFR 435.1009)

FOR DEPARTMENT OF HEALTH AND HUMAN RESOURCES USE ONLY

Form completed, with all necessary information provided.	Yes	No
Medical eligibility established.	Yes	No

_____	_____
Name of Reviewer	Date