

WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES  
PSYCHOLOGICAL EVALUATION

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

DIAGNOSES (DSM IV)

\_\_\_\_\_ Axis I : Clinical Disorders (includes all the mental health conditions not covered by Axis II)

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\_\_\_\_\_ Axis II : Personality Disorders and Mental Retardation

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\_\_\_\_\_ Axis III : General Medical Condition (major medical conditions that may be relevant to treatment of the mental health disorder)

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\_\_\_\_\_ Axis IV : Psychosocial and Environmental Factors

\_\_\_\_\_

\_\_\_\_\_ Axis V : Global Assessment of Functioning

\_\_\_\_\_

SUBSTANTIAL ADAPTIVE DEFICITS (Attach reports/assessments as appropriate)

_____	SELF CARE	_____
_____	COMMUNICATION	_____
_____	RECEPTIVE LANGUAGE	_____
_____	EXPRESSIVE LANGUAGE	_____
_____	LEARNING	_____
_____	FUNCTIONAL ACADEMICS	_____
_____	MOBILITY	_____
_____	SELF DIRECTION	_____
_____	INDEPENDENT LIVING	_____
_____	HOME LIVING	_____
_____	SOCIAL SKILLS	_____
_____	EMPLOYMENT	_____
_____	HEALTH & SAFETY	_____
_____	COMMUNITY USE	_____
_____	LEISURE	_____

I certify that this individual's diagnoses and adaptive deficits are as documented above, and the individual, 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 \_\_\_\_\_ Signature of Licensed Psychologist \_\_\_\_\_ License #