WEST VIRGINIA DEPARTMENT OF HEALTH AND HUMAN RESOURCES
MENTAL DISABILITY/INCAPACITY EVALUATION

DATE: _____ County: _____

TO: Community Services Manager, District _____
Attn: _____

FROM: Medical Review Team, Division of Family Assistance

SUBJECT: Recommendation of Medical Review Team for:

Case Name: _____
Client Name (if different): _____
Address: _____
_____

☐ New Application ☐ Reconsideration ☐ Change in
☐ Reapplication ☐ QA or Fair Hearing Deprivation Factor
☐ Re-evaluation ☐ WV WORKS Exemption to Incapacity

I. Is the material submitted sufficient to permit a determination? ☐ Yes ☐ No
If "No" what additional information is needed?

Medical _____
_____

Social _____

II. After considering all information a decision has been made that the above client is mentally:

☐ Disabled – SSI-Related Medicaid 18/Over
☐ Disabled – SSI-Related Medicaid Under 18
☐ Disabled – Medicaid Work Incentive – 18/Over
☐ Disabled – Medicaid Work Incentive – Under 18
☐ Disabled – Medicaid Work Incentive – Medically-Improved - 18/Over
☐ Disabled – Medicaid Work Incentive – Medically-Improved Under 18
☐ Incapacitated – WV WORKS Exemption
☐ Incapacitated – AFDC Medicaid
☐ Incapacitated – AFDC-Related Medicaid

III. After considering all information a decision has been made that the above client is not mentally:

☐ Disabled – SSI-Related Medicaid 18/Over
☐ Disabled – SSI-Related Medicaid Under 18
☐ Disabled – Medicaid Work Incentive – 18/Over
☐ Disabled – Medicaid Work Incentive – Under 18
☐ Disabled – Medicaid Work Incentive – Medically-Improved - 18/Over
☐ Disabled – Medicaid Work Incentive – Medically-Improved Under 18
☐ Incapacitated – WV WORKS Exemption
☐ Incapacitated – AFDC Medicaid
☐ Incapacitated – AFDC-Related Medicaid

IV. Remarks

A. Is the client currently performing substantial gainful activity? ☐ Yes ☐ No
(If yes, please explain on next page.)

B. Does the client have a medically determinable impairment or combination of impairments which significantly limits ability to perform basic work activity?
(If no, please explain on next page.) ☐ Yes ☐ No

C. Does the client's impairment(s) meet or equal the listing of impairments? ☐ Yes ☐ No

D. Does the client's impairment(s) prevent performance of past relevant work?
(If no, please explain below.) ☐ Yes ☐ No

E. Does the client's impairment(s) prevent performance of other work considering age, education, work experience or residual functional capacity?
(If no, please explain below.) ☐ Yes ☐ No

_____

_____

_____

_____

_____

V. Referral

Does the information submitted indicate that the client should be referred to the Division of Rehabilitative Services: ☐ Yes ☐ No

VI. Re-evaluation

A. The information submitted indicates that the case must be re-evaluated on _____, unless the Worker determines that the client needs an earlier evaluation.

The following information must be included with the original material when the case is submitted for re-evaluation.

☐ Medical reports from the last MRT submittal
☐ Current report from attending physician
☐ Updated social summary
☐ Other as specified: _____

_____

_____

_____

OR

B. ☐ Does not require re-evaluation.

Date: _____

_____ _____
Review Team Examiner Reviewing Psychiatrist