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

Date: _____ Co._____

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 to
❒ Reevaluation	❒ WV WORKS Exemption	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:

❒ 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:

❒ 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? ❒ Yes ❒ No
(If no, please explain on next page.)

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?
❒ Yes ❒ No (If no, please explain below.)

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

_____

_____

_____

_____

_____

V. Referral

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

VI. Reevaluation

A. The information submitted indicates that the case must be reevaluated 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 reevaluation:

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

_____

_____

_____

Or B. Does not require reevaluation.

Date: _____

_____ _____

Review Team Examiner *Reviewing Physician*