

55 WEST VIRGINIA MEDICAL INSTITUTE, INC.
3100 Chesterfield Ave. Charleston, WV 25304
Evaluation Request/Medicaid Aged and Disabled Waiver Program
Confidential
WVMI Local Fax # 304-346-8948 * * Toll Free Fax # 1-800-293-3009

___ Initial ___ Re-evaluation

ENTIRE FORM MUST BE COMPLETED IN ORDER TO PROCESS

APPLICANT INFORMATION:

Name: _____ Birth Date: ___/___/___ SS#: ___/___/___

Medicaid #: _____ Phone #: _____ County: _____

Address: _____ City: _____ State: _____ Zip: _____

CHECK ONE IF APPLICABLE: ___ Guardian ___ Power of Attorney ___ Committee

Contact Person: _____ Phone #: _____
(If other than applicant)

Contact's Address: _____ Relationship to Applicant: _____

Signature of Applicant or Representative

Date

Case Management Name: _____ Phone #: _____

Fax #: _____ Address: _____

REFERRING PHYSICIAN'S INFORMATION

Name: _____ Phone #: _____ Fax #: _____

Address: _____ City: _____ State: _____ Zip: _____

Applicant's Diagnoses (with comments): _____

Any Other Pertinent Medical Conditions: _____

Does the Individual have Alzheimer's, Multi-Infarct, Senile Dementia, or Related Conditions? Yes No

Is the Patient Terminal? Yes No

Physician's Signature (Original Required)

Date