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

Date: _____ Co. _____

To: CSM - District _____
Attention: _____

From: Medical Review Team, Division of Family Assistance

Subject: Recommendation of Medical Review Team for:
Case Name: _____
Client Name (if different): _____

MA ID Pending Medicaid No.: _____
Address: _____
_____

❒ New Application ❒ Reconsideration ❒ Change in Deprivation
❒ Reapplication ❒ QA or Fair Hearing Factor to Incapacity
❒ Reevaluation ❒ WV WORKS Exemption

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 - AFDC Medicaid
❒ Incapacitated - AFDC-Related Medicaid
❒ Incapacitated - WV WORKS Exemption

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

❒ Disabled - SSI-Related Medicaid Age 18 or 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 - AFDC Medicaid
❒ Incapacitated - AFDC-Related Medicaid
❒ Incapacitated - WV WORKS Exemption

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

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

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 psychiatrist
❒ Updated social summary
❒ Other as specified:_____

_____

_____

B. Does not require reevaluation.

Date: _____

_____ Review Team Examiner

_____ Reviewing Psychiatrist