Disability/Incapacity Medical Assessment

Patient Name: _____ Date of Birth: _____

Social Security Number: _____ WV DHHR Worker: _____

I hereby request that the following health information be released to the West Virginia Department of Health and Human Resources (WV DHHR). Furthermore, I understand that this information will be kept confidential and will be used for program purposes only.

_____ _____
Signature of Applicant Date

You have indicated to a representative of the WV DHHR or one of its partners that you are unable to work or participate in the required activities because of your medical condition. To assist WV DHHR in making accommodations for your work activity, a current medical assessment must be provided by your current attending physician or his/her representative. This information must be verified by your attending medical provider. You must return this information to the WV DHHR no later than _____. Failure to return this information by the above date may result in an unfavorable decision on your benefits. Your current attending medical provider must supply the following information:

- Diagnosis: _____ Date of last patient contact:_____
- Prognosis: _____
- Length of time disability/incapacity is expected to last:_____
- Employment limitations/difficulties this condition places on this individual: _____
  _____
- Accommodations that can be made so this individual could participate in community service or similar activity: _____
  _____
- Is this individual able to participate in an educational activity with accommodations? __Yes __No
  If no, please explain why not: _____
- Accommodations that can be made so this individual could participate in an educational activity/ classroom setting: _____
  _____
- Is this individual able to participate in a work or educational activity at least 5 hours per week with accommodations? ___Yes ___No
  If no, please explain why not:
  _____
- Is this individual's disability/incapacity such that it is necessary for someone to stay in the home with him/her on a continuous basis? ___Yes ___No
- Is this individual able to care for children under age six? ___Yes ___No

_____ _____
Medical Provider's Signature/Date

_____
Address

_____ _____
Printed Name Phone