# AGED AND DISABLED WAIVER PROGRAM
# MEDICAL NECESSITY EVALUATION REQUEST

For initial evaluation, please send to
KEPRO, ADW Program, 100 Capitol Street, Suite 600
Charleston, WV 25301 Fax: Toll Free Fax: 866-212-5053
For reevaluations, send to case management agency below
Please check one:____ Initial____/Reevaluation

**APPLICANT/PARTICIPANT INFORMATION:**
Name:_____Date of Birth____/____/____Sex_____(check one)___M___F
SSN:_____ Medicaid #:_____Medicare #: _____
Physical Address: _____ City: _____State: _____Zip:_____
Mailing Address: _____City:_____ State: _____Zip: _____
Phone #: _____ County of Residence: _____

_____ _____
**Signature of Applicant/Participant** **Date**

**LEGAL REPRESENTATIVE, GUARDIAN OR CONTACT INFORMATION:** (Required if applicant/participant has Alzheimer's, dementia or a Related diagnoses)

Name: _____ Phone #: _____
Mailing address: _____ City: _____State: _____ Zip: _____
Relation to Applicant/Participant: _____
(check one):
___Guardian___Committee ___Power of Attorney___Medical Power of Attorney___Durable Power of Attorney_____Contact

_____ _____
**Signature of Legal Representative (no signature needed if contact person)** **Date**

**CASE MANAGEMENT AGENCY or FISCAL EMPLOYER AGENT INFORMATION: (Reevaluations Only)**

Agency Name: _____ Case Manager/Resource Consultant: _____
Mailing Address: _____ City: _____ State: _____ Zip: _____
Phone #: _____ Fax #: _____

**REFERRING PHYSICIAN'S INFORMATION**: (This information may be shared with the applicant/participant.)
**THIS INFORMATION MUST BE LEGIBLE OR THE REQUEST WILL NOT BE PROCESSED.**

Name (MD, DO, PA, Nurse Pracitioner):_____ Phone #: _____ Fax #: _____
Mailing Address: _____ City: _____ State: _____ Zip: _____
Patient's Diagnoses and ICD-10 codes:
_____
_____
_____
Other Pertinent Medical Conditions: _____
_____

Does the individual have Alzheimer's, brain multi-infarct, senile dementia or a related condition: (circle one) ___Yes ___No
**If yes, please specify:**_____

Is the patient terminal? (check one)___Yes ___No

_____ _____
**Signature of Physician (MD, DO, PA or Nurse Practitioner; original required)** **Date (valid for 60 days)**