WEST VIRGINIA I/DD WAIVER
ANNUAL FUNCTIONAL ASSESSMENT DATA MODIFICATION REQUEST

This is a formal request that the UMC modify information collected during the annual functional assessment. All information submitted to the UMC must be in writing, and this form must be completed in its entirety prior to the UMC considering your request.

1. **Person Requesting Change** (may only be the person who receives services or his/her legal representative)	
2. **Address** (how might the UMC reach you by mail?)	
3. **Phone Number** (how might the UMC reach you by phone?)	
4. **Service Coordination Agency** (which agency provides Service Coordination?)	
5. **Name/APS ID of Person Who Receives Services**	
7. **What information do you feel is incorrect on the annual functional assessment(s)? This information must be specific. An indication that the assigned budget is not enough will not justify consideration.** (use additional pages, as necessary)	
8. **Why do you feel the information is incorrect?** (use additional pages, as necessary)	
9. I believe the assessment information collected by the UMC does not accurately reflect _____'s abilities and support needs. I formally request that the UMC consider revising/modifying assessment information. I understand that a reassessment will not occur. **Signature (required):_____ Date: _____**	

Send via mail, fax or email to: APS Healthcare 100 Capitol Street, Suite 600 Charleston, WV 25301
Fax: (866) 521-6882 Email: wviddwaiver@apshealthcare.com