



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