



## WV PERSONAL CARE PROGRAM MEDICAL NECESSITY EVALUATION REQUEST (PC-MNER)

ALL INFORMATION MUST BE LEGIBLE, OR THE REQUEST CANNOT BE PROCESSED

**Type of Request** (please check one):  Initial  Reevaluation  Emergency/Facility Discharge

**Submit Initial and Emergency PCMNERS to** KEPRO-PC | 1007 Bullitt Street, Suite 200 | Charleston, WV 25301 | FAX-844-794-6729

**Physicians, submit Reevaluation PC-MNERS to the Personal Care Agency at Fax:** \_\_\_\_\_

<b>APPLICANT/MEMBER INFORMATION</b>			
First Name:	Middle Name:	Last Name:	Suffix:
Date of Birth:	Gender: <input type="checkbox"/> MALE <input type="checkbox"/> FEMALE	Is the person in a Specialized Family Care Home? <input type="checkbox"/> YES <input type="checkbox"/> NO	
SSN:	Medicaid #:	Medicare #	Dual Services? <input type="checkbox"/> YES <input type="checkbox"/> NO If yes, select Type of Waiver: <input type="checkbox"/> IDDW <input type="checkbox"/> TBIW <input type="checkbox"/> ADW
Member's Physical Address (Indicate Facility's name and contact info if the request is for Emergency/Facility Discharge):			
Member's Mailing Address:			
County of Residence (or Facility's County)		Member's Phone # (or Facility's Phone #):	
Signature of Applicant/Member	X		Date:
<input type="checkbox"/> Check if Applicant/Member is his/her own Legal Representative			
LEGAL REPRESENTATIVE, GUARDIAN, OR CONTACT INFORMATION (REQUIRED IF APPLICANT/MEMBER HAS ALZHEIMER'S, DEMENTIA OR RELATED DIAGNOSES OR IS UNDER THE AGE OF 18-- ALL ARE ENCOURAGED TO LIST A CONTACT PERSON TO ASSIST)			
Name:		Phone #:	
Mailing Address:			
Relationship to Applicant/Member	<input type="checkbox"/> Guardian <input type="checkbox"/> Committee <input type="checkbox"/> Power of Attorney <input type="checkbox"/> Medical Power of Attorney <input type="checkbox"/> Durable Power of Attorney <input type="checkbox"/> Contact/Other (describe): _____		
Signature of Legal Representative (not needed if contact person)	X		Date:
<b>REFERRING PHYSICIAN'S INFORMATION</b> (This information may be shared with the applicant/member).			
Name (MD, DO, PA, Nurse Practitioner)		Phone #	Fax #
Mailing Address (include city, state, zip):			
Patient Diagnoses			
Other Pertinent Medical Conditions:			
Does the individual have Alzheimer's, brain multi-infarct, senile dementia or a related condition?		<input type="checkbox"/> Yes <input type="checkbox"/> No	If "Yes," please specify
Is the patient terminal?	<input type="checkbox"/> Yes <input type="checkbox"/> No		
Signature of Physician (MD, DO PA or Nurse Practitioner; original required)	X		Date (valid for 60 days):