

**AGED AND DISABLED WAIVER PROGRAM  
MEDICAL NECESSITY EVALUATION REQUEST**

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

Type of Request:  **Initial**. Submit to: KEPRO-ADW | 100 Capitol Street, Suite 600, Charleston, WV 25301, FAX: 866-212-5053  
 **Reevaluation**. Send completed form to Case Manager: \_\_\_\_\_ FAX: \_\_\_\_\_

<b>APPLICANT/PARTICIPANT INFORMATION</b>		
Name:	Date of Birth:	Sex: <input type="checkbox"/> M <input type="checkbox"/> F
SSN #:	Medicaid #:	Medicare #:
Physical Address:		
Mailing Address:		
Phone #:	County of Residence:	
<b>Signature of Applicant/Participant</b>	<b>X</b>	Date:
<b>CONTACT INFORMATION (REQUIRED IF APPLICANT/PARTICIPANT HAS ALZHEIMER'S, DEMENTIA OR RELATED DIAGNOSES) - ALL APPLICANTS ARE ENCOURAGED TO LIST A CONTACT PERSON</b>		
Name:	Phone #:	
Mailing Address:		
Relationship to Applicant/Participant: (Choose <u>ONLY ONE</u> type of relationship)	<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 Person	
<b>Signature of Legal Representative (not needed if contact person)</b>	<b>X</b>	Date:
<b>CASE MANAGEMENT AGENCY OR FISCAL EMPLOYER AGENT INFORMATION (Reevaluation Only)</b>		
Agency Name:	Phone #:	Fax #:
Case Manager/Resource Consultant:		
Mailing Address:		
<b>REFERRING PHYSICIAN'S INFORMATION (This information may be shared with the applicant/participant).</b>		
Name: (MD, DO, PA, Nurse Practitioner)	Phone #:	Fax #:
Mailing Address:		
<b>Patient Diagnoses and other Pertinent Medical Conditions:</b>	<b>ICD-10 codes:</b>	
Is the patient terminal? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Does the patient have Alzheimer's, brain multi-infarct, senile dementia or a related condition?		
<input type="checkbox"/> Yes <input type="checkbox"/> No    If "Yes," please specify:		
<b>Signature of Physician (MD, DO, PA or Nurse Practitioner; original required)</b>	<b>X</b>	Date (valid for 60 days):