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: _____

APPLICANT/MEMBER INFORMATION			
First Name:	Middle Name:	Last Name:	Suffix:
Date of Birth:	Gender: ☐ MALE ☐ FEMALE	Is the person in a Specialized Family Care Home? ☐YES ☐NO	
SSN:	Medicaid #:	Medicare #	**Dual Services?** ☐YES ☐NO **If yes, select Type of Waiver:** ☐IDDW ☐ TBIW ☐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:	
☐ 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	☐ Guardian ☐ Committee ☐ Power of Attorney ☐ Medical Power of Attorney ☐ Durable Power of Attorney ☐ Contact/Other (describe): _____	
Signature of Legal Representative (not needed if contact person)	X	Date:

REFERRING PHYSICIAN'S INFORMATION (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?	☐ Yes ☐ No	If "Yes," please specify	
Is the patient terminal?	☐ Yes ☐ No		
Signature of Physician (MD, DO PA or Nurse Practitioner; original required)	X	Date (valid for 60 days):	

Form Effective 4-11-18