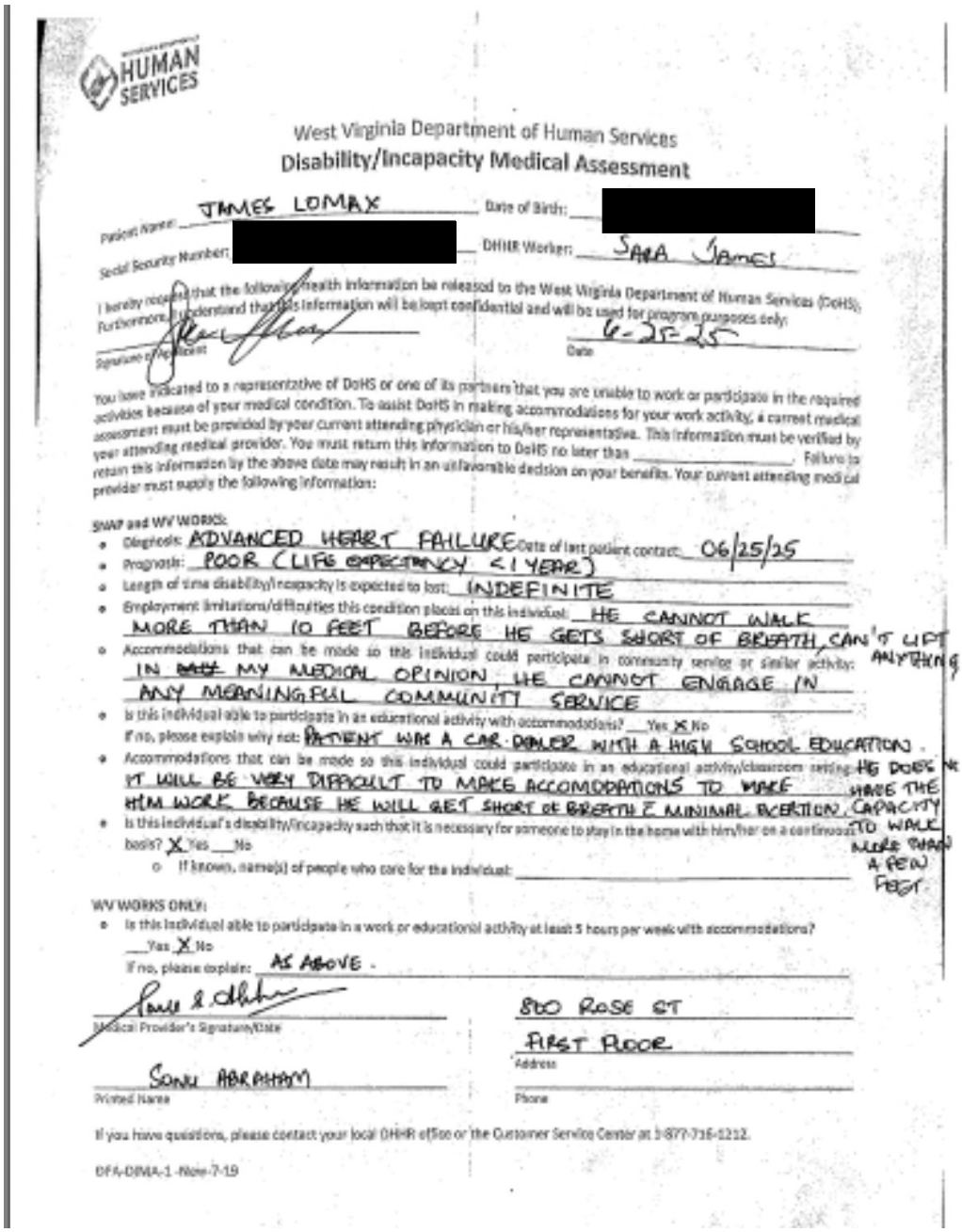

HUMAN SERVICES

West Virginia Department of Human Services

Disability/Incapacity Medical Assessment

Patient Name: JAMES LOMAX Date of Birth: [redacted]

Social Security Number: [redacted] DHHR Worker: SARA JAMES

I hereby request that the following health information be released to the West Virginia Department of Human Services (DoHS). Furthermore, I understand that this information will be kept confidential and will be used for program purposes only.

Signature of Applicant 6-25-25 Date

You have indicated to a representative of DoHS or one of its partners that you are unable to work or participate in the required activities because of your medical condition. To assist DoHS 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 DoHS 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:

SNAP and WV WORKS:

- Diagnosis: ADVANCED HEART FAILURE Date of last patient contact: 06/25/25
- Prognosis: POOR (LIFE EXPECTANCY <1 YEAR)
- Length of time disability/incapacity is expected to last: INDEFINITE
- Employment limitations/difficulties this condition places on this individual: HE CANNOT WALK MORE THAN 10 FEET BEFORE HE GETS SHORT OF BREATH, CAN'T LIFT ANYTHING
- Accommodations that can be made so this individual could participate in community service or similar activity: ~~IN MY~~ IN MY MEDICAL OPINION HE CANNOT ENGAGE IN ANY MEANINGFUL COMMUNITY SERVICE
- Is this individual able to participate in an educational activity with accommodations? ___Yes X No
  If no, please explain why not: PATIENT WAS A CAR DEALER WITH A HIGH SCHOOL EDUCATION.
- Accommodations that can be made so this individual could participate in an educational activity/classroom setting: HE DOES NOT HAVE THE CAPACITY TO WALK MORE THAN A FEW FEET. IT WILL BE VERY DIFFICULT TO MAKE ACCOMODATIONS TO MAKE HIM WORK BECAUSE HE WILL GET SHORT OF BREATH E MINIMAL EXERTION.
- 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? X Yes ___No
  - If known, name(s) of people who care for the individual: _____

WV WORKS ONLY:

- Is this individual able to participate in a work or educational activity at least 5 hours per week with accommodations?
  ___Yes X No
  If no, please explain: AS ABOVE.

Medical Provider's Signature/Date

SONU ABRAHAM
Printed Name

800 ROSE ST
FIRST FLOOR
Address

Phone

If you have questions, please contact your local DHHR office or the Customer Service Center at 1-877-716-1212.

DFA-DIMA-1 -Rev-7-19

EXHIBIT 1