Ohio Department of Developmental Disabilities

Diagnosis Verification (Ages 10 and above)

Individual: ____ DOB: __________________

Please complete only one section of the below. It is not necessary to have both areas completed.

Please complete this section if you are a physician or certified nurse practitioner (CNP) providing diagnosis verification.

1. Does the individual have a medical condition that would be defined as a severe, chronic disability?
   Yes No

Please list the person's disability: ____

____

2. Was the onset of the condition prior to age 22? Yes No
3. Is the disability attributable to a physical or mental condition other than a sole diagnosed mental health condition?
   Yes No
4. Is this condition likely to continue indefinitely? Yes No

Physician or CNP's Name: ____ License #: _________________

Physician or CNP's Signature: ____ Date: ____________

Please complete this section if you are a licensed psychologist providing diagnosis verification.

1. Does the individual have a developmental or intellectual disability that would be defined as a severe, chronic disability? Yes No

Please list the person's disability: ____

____

2. Please list the instrument used to determine the presence of the disability and date administered:

   Instrument: ____ Date: ________________

3. Was the onset of the condition prior to age 22? Yes No
4. Is the disability attributable to a physical or mental condition other than a sole diagnosed mental health condition?
   Yes No
5. Is this condition likely to continue indefinitely? Yes No

Licensed Psychologist's Name: ____ License #: _________________

Licensed Psychologist' s Signature: ____ Date: ____________