

Diagnosis Verification (Ages 10 and above)

Individual: _____

DOB: _____

Please have the appropriate clinician complete the below information. It is not necessary to have both areas completed.

Please complete this section if you are a **physician** 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's Name: _____ License #: _____

Physician's Signature: _____ Date: _____

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

1. Does the individual have an 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: _____