Seneca County Opportunity Center

SENECA COUNTY BOARD OF DEVELOPMENTAL DISABILITIES

Verification of Developmental Disability Diagnosis

Individual: _____ DOB: _____

[The appropriate clinician should complete only one section below. 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 both a severe AND chronic disability?

   ☐ Yes ☐ No

   Please list the person's disability: _____

   _____

*Please indicate the instruments used to determine the presence of this disability (psychological testing, medical testing, etc.) and the dates administered:

Instrument:_____ Result: _____ Date: _____

1. Was the onset of the condition prior to the age of 22? ☐ Yes ☐ No
2. Is the disability caused by mental illness only? ☐ Yes ☐ No
3. Is this condition likely to continue indefinitely? ☐ Yes ☐ No

Clinician name: _____ License number: _____

Clinician 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 both a severe AND chronic disability?

   ☐ Yes ☐ No

   Please list the person's disability: _____

   _____

*Please indicate the instruments used to determine the presence of this disability (psychological testing, medical testing, etc.) and the dates administered:

Instrument:_____ Result: _____ Date: _____

2. Was the onset of the condition prior to the age of 22? ☐ Yes ☐ No
3. Is the disability caused by mental illness only? ☐ Yes ☐ No
4. Is this condition likely to continue indefinitely? ☐ Yes ☐ No

Clinician name: _____ License number: _____

Clinician signature: _____ Date: _____

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ADHD Diagnosis Confirmation

(Form to be completed in addition to the Diagnosis Verification form for eligibility determination if primary diagnosis is ADHD)

Individual: _____ DOB: _____

* In the past 6 months, has the individual been prescribed and taken medication(s) to treat symptoms of ADHD?

☐ Yes ☐ No

Please list the medication(s) and dosage(s) prescribed: _____

_____

*Please list ADHD symptoms the individual is CURRENTLY exhibiting: _____

_____

_____

*In the past 6 months, have the ADHD symptoms listed above interfered with or reduced the quality of the individual's ability to function at: ☐ School ☐ Home ☐ Work

(*Please check all that apply*)

Clinician name: _____ License number: _____

Clinician signature: _____ Date: _____

Please Return Completed Forms to:

Seneca County Board of DD
Attn: Lexie Fretz, Intake Coordinator
780 E. CR 20
Tiffin, OH 44883

lefretz@senecadd.org
Phone: 419-447-7521
ext. 1119
Fax: 419-448-5294