Ohio Department of Developmental Disabilities

Diagnosis Verification (Ages birth through age 9)

Individual: _____ DOB: _____

Please have the appropriate clinician complete the below information.

Does the child have at least one of the following:

1. A substantial developmental delay?

☐ Yes ☐ No

In what area(s) do delay(s) exist? _____

_____

Instrument: _____ Date administered: _____

OR

2. A diagnosed congenital or acquired condition (other than an impairment caused solely by a mental illness)?

☐ Yes ☐ No

List the diagnoses: _____

Is the person receiving treatment for this diagnosis (treatment can include medication, counseling or therapy)?

☐ YES ☐ NO If yes, What type of treatment: _____

3. The above-mentioned condition and/or delay likely to result in substantial functional limitation in any of the following major life areas if the child does not receive the appropriate services/supports (check all that apply:)

Self-care (bathing, grooming, eating, toileting, etc.)	☐
Expressive/receptive language	☐
Learning/cognition	☐
Mobility (locomotion, positioning, transfers)	☐
Self-direction (decision-making, judgment)	☐
Independent living (household tasks)	☐
Economic proficiency (money management)	☐

_____ _____

Name of Clinician License number

_____ _____

Signature of Clinician Date