CONFIRMATION OF DIAGNOSIS

State Form 54727 (R / 10-15)
INDIANA FAMILY AND SOCIAL SERVICES ADMINISTRATION (IFSSA)
DIVISION OF DISABILITY AND REHABILITATIVE SERVICES (BDDS)

Reset Form

CONFIDENTIAL

Physician Note: An electronic version of this form may be found on the Division of Disability and Rehabilitative Services' website at www.IN.Gov/fssa/q2328.htm.
This document may be located at "About DDRS" and then under "FORMS".
Please complete the form, print, sign and return to the consumer to take to his/her local BDDS office.

I – CONSUMER INFORMATION

Last name	First name	Middle initial

Street address *(number and street)*	City	State	ZIP code
		Indiana	

County of residence	Date of birth *(month, day, year)*	Sex	Telephone number	Last 4 digits of Social Security number
			( )	XXX – XX -

II – DEVELOPMENTAL DISABILITY (DD) DIAGNOSIS

Federal and state regulations require a physician's confirmation that the individual's developmental disability / intellectual disability (DD/ID) condition manifested before the age of twenty-two (22).

Primary diagnosis	Date of primary diagnosis *(month, day, year)*

Other conditions *(Excluding mental illness)*

Secondary diagnosis	Date of secondary diagnosis *(month, day, year)*

Tertiary diagnosis	Date of tertiary diagnosis *(month, day, year)*

Signature of physician	Date signed *(month, day, year)*

Printed name of physician	Telephone number
	( )

Street address *(number and street)*	City	State	ZIP code
		Indiana	

III – FOR OFFICE USE ONLY

Signature of BDDS staff	Print name of BDDS staff	Date *(month, day, year)*

Comments: