



CONFIRMATION OF DIAGNOSIS

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

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
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

III – FOR OFFICE USE ONLY

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