

**Qualifying Diagnosis Certification**

for

Intellectual and Developmental Disabilities Program

**Applicant/participant:** \_\_\_\_\_

Date of birth: \_\_\_\_\_ Medicaid number: \_\_\_\_\_

The information requested will assist SDS to determine if the applicant/participant qualifies for services. Please send to the care coordinator or agency representative at the Fax number or email address indicated:

**Care coordinator/representative:** \_\_\_\_\_

Fax number: \_\_\_\_\_ Email: \_\_\_\_\_

**Diagnosis** (Initial all that apply to the applicant/participant.) **Failure to provide the ICD-9 code will result in this form being returned to the Care Coordinator for correction.**

The individual meets the diagnostic criteria for:

ICD-9 Code \_\_\_\_\_  Mental retardation (according to the DSM-IV- TR, diagnosed by a licensed psychologist, psychological associate, or developmental pediatrician).

ICD-9 Code \_\_\_\_\_  Condition (other than mental illness, psychiatric impairment, or a serious emotional or behavioral disturbance) that is closely related to mental retardation because it results in impairment of general intellectual functioning and adaptive behavior and that requires treatment or services similar to those required for individuals with mental retardation (diagnosed by a licensed physician).  
Please specify diagnosis:  
\_\_\_\_\_

ICD-9 Code \_\_\_\_\_  Cerebral Palsy (diagnosed by a licensed physician).

ICD-9 Code \_\_\_\_\_  Seizure disorder (diagnosed by a licensed physician).

ICD-9 Code \_\_\_\_\_  Autistic Disorder- code 299.00 (diagnosed by a clinical psychologist, child psychologist, or developmental pediatrician).

ICD-9 Code \_\_\_\_\_ Additional diagnoses (with comments) \_\_\_\_\_

**Onset** Please indicate the age of onset of the diagnosed condition: \_\_\_\_\_

*To the best of my knowledge, the above information is true, accurate, and complete:*

\_\_\_\_\_  
Signature Date License #

\_\_\_\_\_  
Name (please print) Telephone number

\_\_\_\_\_  
Physical Address

**Questions may be directed to Senior and Disabilities Services at 269-3666 or 1-800-478-9996.**

This form may be completed by the following individuals licensed to practice in Alaska: Physician, Advanced Nurse Practitioner, Physician's assistant, Psychologist, Psychological Associate or Certified School Psychologist.