JCBDD
Jackson County Board of Developmental Disabilities

822 Sellers Drive • P.O. Box 607
Jackson, OH 45640
740.286.6491
fax: 740.286.6657
www.jcbdd.org
Nick Elliott, *Superintendent*

Jackson County Board of Developmental Disabilities
SSA Department
202 S. Pennsylvania Ave.
Wellston, OH 45692
Phone: (740) 384-7938 Fax: (740) 384-3603

Applicant must complete the following:

- Medical Evaluation Report
- Social Service Summary
- Diagnosis Verification Form

Applicant must provide copies of the following:

- Insurance Card (s)
- State ID
- Birth Certificate
- Social Security Card
- Guardianship papers (if applicable)

➢ **All the above referenced documentation must be received before eligibility determination can be made.**

Return all forms to: Jackson County Board of DD
Service and Support Administration Dept.
202 S. Pennsylvania Ave.
Wellston, Ohio 45692

Ohio Department of Developmental Disabilities

Diagnosis Verification (Ages 10 and above)

Individual: _____ DOB: _____

Please complete only one section of the below. It is not necessary to have both areas completed.

Please complete this section if you are a physician or certified nurse practitioner (CNP) providing diagnosis verification.

1. Does the individual have a medical condition that would be defined as a severe, chronic disability?
   ☐ Yes ☐ No

Please list the person's disability: _____

_____

2. Was the onset of the condition prior to age 22? ☐ Yes ☐ No
3. Is the disability attributable to a physical or mental condition other than a sole diagnosed mental health condition?
   ☐ Yes ☐ No
4. Is this condition likely to continue indefinitely? ☐ Yes ☐ No

Physician or CNP's Name: _____ License #: _____

Physician or CNP's Signature: _____ Date: _____

Please complete this section if you are a licensed psychologist providing diagnosis verification.

1. Does the individual have a developmental or intellectual disability that would be defined as a severe, chronic disability? ☐ Yes ☐ No

Please list the person's disability: _____

_____

2. Please list the instrument used to determine the presence of the disability and date administered:

   Instrument: _____ Date: _____

3. Was the onset of the condition prior to age 22? ☐ Yes ☐ No
4. Is the disability attributable to a physical or mental condition other than a sole diagnosed mental health condition?
   ☐ Yes ☐ No
5. Is this condition likely to continue indefinitely? ☐ Yes ☐ No

Licensed Psychologist's Name: _____ License #: _____

Licensed Psychologist' s Signature: _____ Date: _____

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 above-mentioned condition and/or delay likely to result in substantial functional limitation in any of the following major life areas if the individual does not receive the appropriate services/supports?

Self-care (bathing, grooming, eating, toileting, etc.)	☐ Yes	☐ No
Expressive/receptive language	☐ Yes	☐ No
Learning/cognition	☐ Yes	☐ No
Mobility (locomotion, positioning, transfers)	☐ Yes	☐ No
Self-direction (decision-making, judgment)	☐ Yes	☐ No
Independent living (household tasks)	☐ Yes	☐ No
Economic proficiency (money management)	☐ Yes	☐ No

_____ _____

Name of Physician or Licensed Psychologist — License number

_____ _____

Signature of Physician or Licensed Psychologist — Date

Ohio | Department of Developmental Disabilities

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1. Date of Medical Evaluation:_____
2. Name of Individual:_____
3. Address:_____
4. Date of Birth:_____Sex _____Male_____Female
5. Current Medications schedule (name, dose, route, and frequency)

   _____
   _____
   _____
   _____
   _____
   _____
   _____

6. Drug Allergies:_____
7. Environmental Allergies:_____
8. Skin Problems:_____
9. Diet, Eating Problems:

   _____
   _____

10. Surgeries:_____
11. Injuries:_____
12. Menstrual History (if applicable):_____
13. Physical Examination:

    Height_____ Weight _____ Pulse_____

    Respiratory Rate:_____ BP:_____

    HEENT:_____

    Abdomen:_____

    Chest: _____

    Heart: _____

    Extremities:_____

Neurological:_____

Visual Activity: OS_____ OD_____

Hearing Activity: Left:_____ Right:_____

14. Behavioral Status:_____

_____

15. Diagnosis:_____

_____

16. Recommendations:

Activity: _____ Full Participation _____ Restricted Participation

A. List and Explain any restricitons:_____

_____

B. Medical Data relevant to the development of an individual Service Plan:_____

_____

_____

Physician's Name: _____

Physician's Signature: _____

Physician's Address: _____

Physician's Phone Number: _____

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Initial Social Summary

I. General

Full Legal Name: _____

Address: _____

Phone Number: _____

Email Address: _____

Date of Birth: _____

Sex: ☐ M ☐ F Race: _____ Marital Status: _____

Social Security No.: _____ Medicaid No.: _____

Medicare No.: _____

Other Medical Insurance: _____ Policy #: _____

II. Legal Status

Legal Guardian Name: _____

Guardian Address: _____

Relationship to Applicant: _____

Guardian Phone Number: Home _____ Cell _____

Guardian Email Address: _____

Guardian Type: _____

Date Appointed: _____

III. Family History

Mother:

Name: _____

Address: _____

Phone Number: _____

Date of Birth: _____ If deceased, date: _____

Father:

Name: _____

Address: _____

Phone Number: _____

Date of Birth: _____ if deceased, date: _____

Siblings

1. Name:_____Age_____

2. Name:_____Age_____

3. Name:_____Age_____

4. Name:_____Age_____

Advocate/Other interested family/friends:

1. Name:_____Age_____
   Address:_____Phone #:_____

2. Name:_____Age_____
   Address:_____Phone #:_____

Additional Comments: _____
_____
_____

Emergency Contacts:

1. Name:_____Relationship_____
   Address:_____Phone #:_____

2. Name:_____Relationship_____
   Address:_____Phone #:_____

IV. Financial

SSI:_____ SSA:_____VA:_____
Other income (specify)_____

Representative Payee:

1. Name:_____
   Address:_____Phone #:_____
   Relationship:_____

V. Medical Information

Primary Care Physician:

Name:_____

Address:_____Phone #:_____

Dentist:

Name:_____

Address:_____Phone #:_____

Specialty Physicians

Name:_____

Address:_____Phone #:_____

VI. Education/Vocation History

School(s) attended:

Name:_____

Address:_____

Dates Attended:_____

Name:_____

Address:_____

Dates Attended:_____

Vocational Training:

Name:_____

Address:_____

Dates Attended:_____

VII. Development Center/ICF History

Facility Name:_____

Address:_____

Dates Attended:_____

Reason for DC/ICF stay:_____

VIII. Intellectual Disability

___Mild ___Moderate ____Severe ____Profound

Identified Behavioral issues_____

_____

_____

_____

IX. General Health

A. Birth, Childhood and/or other diseases/conditions:_____

_____

_____

B. Hospitalizations:_____

_____

C. Other Medical Problems:_____

_____

_____

D. Known Allergies:_____

_____

E. Current Medications (dosage and purpose)_____

_____

_____

_____

F. Seizures: _____Yes _____NO

Age of onset: _____

Describe seizure:

_____

_____

_____

_____

X. Preferred Activities:

A. Home:_____

_____

B. Community:_____

_____

XII: General Likes and Dislikes

_____

_____

_____

Informant Signature:_____Date:_____