



Qualifying Diagnosis Certification

Intellectual and Developmental Disabilities Waiver

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: _____

Phone: _____ Fax: _____ Email: _____

Diagnosis (Initial all that apply to the applicant/participant)

Failure to provide the ICD-9 code will result in this form being returned for correction.

ICD-9 code _____ Intellectual Disability (according to the DSM-IV- TR, diagnosed by a licensed psychologist, psychological associate or developmental pediatrician)

Medical Provider's Initials: _____

ICD-9 code _____ Cerebral Palsy (diagnosed by a licensed physician)

Medical Provider's Initials: _____

ICD-9 code _____ Seizure disorder (diagnosed by a licensed physician)

Medical Provider's Initials: _____

ICD-9 code _____ Autistic Disorder- code 299.00 (diagnosed by a clinical psychologist, child psychologist, or developmental pediatrician)

Medical Provider's Initials: _____

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

Medical Provider's Initials: _____

ICD-9 code _____ Additional diagnoses (with comments) _____

Medical Provider's Initials: _____

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

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.