Washington State Department of Social & Health Services
Transforming lives

DEVELOPMENTAL DISABILITIES ADMINISTRATION (DDA)

Epilepsy Verification Request

TO:

FROM:

RE: _____ _____
NAME DATE OF BIRTH

The Developmental Disabilities Administration (DDA) is making an eligibility determination for the above person. In order to make a determination under the condition of Epilepsy, we need the following information. Your cooperation is much appreciated.

Please answer these questions, sign and date, and return to DDA via fax, email, or in the enclosed envelope if this form was mailed to you.

If you have questions, please call me at:

Diagnosis: ☐ Epilepsy ☐ Seizure Disorder

Yes	No	
☐	☐	A diagnosis of Epilepsy or Seizure Disorder by a Board Certified Neurologist.
☐	☐	This diagnosis originated before the individual reached eighteen years of age.
☐	☐	Seizures are currently uncontrolled and ongoing.
☐	☐	Seizures are reoccurring and cannot be controlled by medication.

How did you determine the existence of epilepsy prior to 18 years of age for this individual? What evidence was used for this determination?

_____ _____
PHYSICIAN'S SIGNATURE DATE

Enclosure: Business Reply Envelope
Consent Form