



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                       |  |
|--------------------------|--------------------------|--|
| <input type="checkbox"/> | <input type="checkbox"/> | A diagnosis of Epilepsy or Seizure Disorder by a Board Certified Neurologist.  |
| <input type="checkbox"/> | <input type="checkbox"/> | This diagnosis originated before the individual reached eighteen years of age. |
| <input type="checkbox"/> | <input type="checkbox"/> | Seizures are currently uncontrolled and ongoing.                               |
| <input type="checkbox"/> | <input type="checkbox"/> | 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