MEDICAL SUBSIDY DIAGNOSIS VERFICATION FORM

Child's Name:_____

Child's DOB:_____

Dear parent/guardian,

Please have the appropriate professional fill out the applicable section: Note; diagnosis must be conclusive, not provisional or "rule out".

The documentation to approve medical subsidy MUST be:

- Signed and dated within 12 months of the application.
- Physically or electronically signed by the appropriate professional (listed in the applicable section)

Dear provider,

This child's parent(s) and/or guardian(s) are applying for the medical subsidy program through MDHHS-AGAO office. Adoption/Guardianship medical subsidy is intended to assist with payment for necessary services related to the treatment of a physical, mental, or emotional condition certified by the Adoption and Guardianship Assistance Office (AGAO). Related expenses may include therapies, prescriptions, medical supplies, or laboratory expenses; see AAM 640 for additional information. The child must meet application and eligibility requirements of the program; see AAM 400 for application and eligibility policies. This form will assist our office in determining eligibility for the medical subsidy program for the child listed above. **Please complete the section(s) below that apply to the above-named child. The required professional's signature is listed in the section above the signature line. Only those professionals can diagnose to meet the eligibility requirements for the medical subsidy program.**

The following professions are NOT accepted when signing documentation:
Nurse Practitioner
Licensed Professional Counselor
Masters of Arts
Any Limited Licensed Professional

If the child is diagnosed with an <u>emotional condition</u> (i.e. ODD, PTSD, anxiety or adjustment disorder), please list the diagnoses below:

1._____ 2._____

3._____ 4._____

Licensed Physician, Licensed Psychologist, Licensed Psychiatrist, Licensed Physician, Licensed Physician Assistant or Licensed Master Social Worker signature and printed name below:

_____ _____

Signature and credentials Printed name, credentials and date

If the child is diagnosed with a psychiatric condition (i.e. bipolar disorder or schizophrenia), please list the diagnoses below:

1._____ 2._____

3._____ 4._____

Licensed Psychiatrist, Licensed Psychologist or Licensed Physician signature and printed name below:

_____ _____

Signature and credentials Printed name, credentials and date

If the child is diagnosed with hearing loss, please list the diagnoses below:

1._____ 2._____

3._____ 4._____

Audiologist, Licensed Physician, or Licensed Physician Assistant signature and printed name below:

_____ _____

Signature and credentials Printed name, credentials, date

If the child is diagnosed with orthodontic problems, please list the diagnoses below:

1_____ 2._____

Orthodontist or Dentist signature and printed name below:

_____ _____

Signature and credentials Printed name, credentials, and date

*Please attach comprehensive plan.

If the child is diagnosed with vision problems, please list the diagnoses below:

1._____ 2._____

Optometrist, Ophthalmologist, Licensed Physician, or Licensed Physician Assistant signature and printed name below:

_____ _____

Signature and credentials Printed name, credentials, and date

If the child is diagnosed with an <u>educational/learning condition</u> (i.e. mental impairment, speech and language impairment, learning disability, developmental delay, emotional impairment or autism), please list the diagnoses below:

1._____ 2._____

3._____ 4._____

Psychiatrist, Psychologist, or Speech and Language Pathologist signature and printed name below: Please also include a document or comprehensive evaluation from the past 12 months.

_____ _____

Signature and credentials Printed name, credentials, and date

If a comprehensive evaluation from a Psychiatrist or Psychologist was not completed, please submit a current Individual Education Program (IEP), or a current Individual Family Service Plan (IFSP):

If the child is diagnosed with <u>ADD or ADHD</u>, please indicate which:

1._____

Fully licensed Psychiatrist, Psychologist (comprehensive evaluation required) or Licensed Physician, Licensed Physician Assistant signature and printed name below

_____ _____

Signature and credentials Printed name, credentials, and date

If the child is diagnosed with <u>Fetal Alcohol Spectrum Disorder, Partial Fetal or Fetal Alcohol Syndrome</u> please indicate:

1._____

Medical Geneticist, Neurologist, Licensed Physician, or Licensed Psychiatrist signature and printed name below:

_____ _____

Signature and credentials Printed name, credentials and date

If the child has been diagnosed with <u>Prenatal Drug Exposure</u>, please attach positive lab reports from birth or hospital records indicating Prenatal Drug Exposure from birth:

_____Check if the positive lab reports from birth are attached

_____Check is hospital records from birth are attached

If the child has been diagnosed with a physical condition, including a motor impairment or sensory problems, please list the conditions below: If the condition is due to an accident, please note the date of the accident next to the resulting diagnosis.

1._____	2._____
3._____	4._____
5._____	6._____
7._____	8._____

Licensed Physician or Licensed Physician Assistant signature and printed name below:

_____	_____
Signature and credentials	Printed name, credentials and date