APPLICATION FOR NORTH DAKOTA AUTISM WAIVER

DEPARTMENT OF HEALTH AND HUMAN SERVICES
MEDICAL SERVICES DIVISION
SFN 60618 (08-2026)

Click Here to Clear Field Data

Today's Date

Complete as thoroughly as possible.

The Privacy Act of 1974 requires the following information be provided when individuals are requested to disclose their social security numbers. Disclosure of the social security number is voluntary and it is requested for identification purposes. Failure to disclose this information will not affect participation in this program.

Name of Child		Gender ◯ Male ◯ Female	Age	Social Security Number
Date of Birth	Race - optional			Telephone Number
Green Card:	Green Card Number	Year Issued		☐ N/A
Year Diagnosed with Autism Spectrum Disorder		Provider Who Made Diagnosis		
Child's Street Address		City	State	ZIP Code

FAMILY ORIGIN

Name of Mother	Email Address	Telephone Number	
Address	City	State	ZIP Code

Name of Father	Email Address	Telephone Number	
Address	City	State	ZIP Code

SIBLINGS

Name	Sex	Age	Relationship	Living in Home
				◯ Yes ◯ No
				◯ Yes ◯ No
				◯ Yes ◯ No
				◯ Yes ◯ No
				◯ Yes ◯ No
				◯ Yes ◯ No
				◯ Yes ◯ No

INSURANCE INFORMATION

Medicaid Eligible ◯ Yes ◯ No ◯ Unknown	Medicaid Number
Human Service Zone Issuing Medicaid Number	
Recipient Liability ◯ Yes ◯ No ◯ Unknown	Title IV-E Eligible ◯ Yes ◯ No ◯ Unknown
Emergency Assistance (EA) Eligible ◯ Yes ◯ No ◯ Unknown	
SSI Eligible ◯ Yes ◯ No ◯ Unknown	SSDI Eligible ◯ Yes ◯ No ◯ Unknown

Name of Third-Party Insurance Company	Telephone Number	FAX Number	
Address	City	State	ZIP Code
Name of Policy Holder	Telephone Number	FAX Number	
Address	City	State	ZIP Code
Policy Number			

Name of Third-Party Insurance Company	Telephone Number	FAX Number	
Address	City	State	ZIP Code
Name of Policy Holder	Telephone Number	FAX Number	
Address	City	State	ZIP Code
Policy Number			

Name of Third-Party Insurance Company	Telephone Number	FAX Number	
Address	City	State	ZIP Code
Name of Policy Holder	Telephone Number	FAX Number	
Address	City	State	ZIP Code
Policy Number			

Description of Present Conditions or Issues - include current symptoms, behaviors, severity, and nature of all preceding treatment issues.

Attach and send with the application - A copy of the diagnosis from the professional who made the diagnosis of Autism Spectrum Disorder.

A typed signature is legally binding and equivalent to a handwritten signature.

Parent or Guardian Signature	Date

Mail, FAX, or email completed application and required documents to:

Medical Services - Autism
Department of Health and Human Services
600 E Boulevard Ave Dept 325
Bismarck ND 58505-0250

Phone (701) 328-4630; 711 (TTY)
FAX: (701) 328-1544
Email: dhsautism@nd.gov