# APPLICATION FOR NORTH DAKOTA AUTISM WAIVER

NORTH DAKOTA DEPARTMENT OF HUMAN SERVICES
AUTISM SERVICES UNIT
SFN 60618 (9-2018)

Clear Fields

Complete as thoroughly as possible.

| | | | |
|---|---|---|---|
| | | | Today's Date |
| Name of Child | Gender ☐ Male ☐ Female | Age | Social Security Number |
| Date of Birth | Race (optional) | | |
| Year Diagnosed With Autism Spectrum Disorder | Provider Who Made Diagnosis | | |
| Child's Address | | | |
| City | State | ZIP Code | Telephone Number |

**FAMILY ORIGIN**

| | | | |
|---|---|---|---|
| Name of Father | Telephone Number (Home) | Telephone Number (Work) | |
| Address | City | State | ZIP Code |

| | | | |
|---|---|---|---|
| Name of Mother | Telephone Number (Home) | Telephone Number (Work) | |
| 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 |

**INSURANCE INFORMATION**

| | | |
|---|---|---|
| Medicaid Eligible ☐ Yes ☐ No ☐ Unknown | Medicaid Number | County Issuing Medicaid Number |
| Recipient Liability ☐ Yes ☐ No ☐ Unknown | Estimated Recipient Liability/Average Per Month | |

| | |
|---|---|
| Title IV-E Eligible | ☐ Yes ☐ No ☐ Unknown |
| Emergency Assistance (EA) Eligible | ☐ Yes ☐ No ☐ Unknown |
| SSI Eligible | ☐ Yes ☐ No ☐ Unknown |
| SSDI Eligible | ☐ Yes ☐ No ☐ Unknown |

Insurance Information continued on page 2

**INSURANCE INFORMATION (continued)**

| | | | |
|---|---|---|---|
| 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 Concerns and/or Issues (include current symptoms/behaviors, severity and nature of all preceding treatment issues) |

**Attach/send with the application:**

- release of information (SFN 1059) for the school or service provider that would be making the recommendation for assistive tecnology
- copy of the diagnosis from the professional who made the diagnosis of autism spectrum disorder

By completing this application I understand that its contents may be shared with agencies involved in services. I have completed and attached the release of information for this purpose (SFN 1059).

| | |
|---|---|
| Parent/Guardian Signature | Date |

Please mail, fax or email completed application and required documents to:

State Autism Coordinator
ND Department of Human Services
600 E Boulevard Ave Dept 325
Bismarck ND 58505-0250

phone: 701-328-4630
fax: 701-328-1544
email: dhsautism@nd.gov