APPLICATION FOR NORTH DAKOTA AUTISM WAIVER

NORTH DAKOTA DEPARTMENT OF HUMAN SERVICES
AUTISM SERVICES UNIT
SFN 60618 (10-2020)

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 (Cell)	Email Address	
Address	City	State	ZIP Code

Name of Mother	Telephone Number (Cell)	Email Address	
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			
Title IV-E Eligible ☐ Yes ☐ No ☐ Unknown			
Emergency Assistance (EA) Eligible ☐ Yes ☐ No ☐ Unknown			
SSI Eligible ☐ Yes ☐ No ☐ Unknown			
SSDI Eligible ☐ Yes ☐ No ☐ Unknown			

*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.

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:

- Authorizaion to Disclose Information (SFN 1059) for the school or service provider that would be making the recommendation for assistive technology
- A 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 Authorization to Disclose Information (SFN 1059) for this purpose.

Parent/Guardian Signature - A typed signature is legally binding and equivalent to a handwritten 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