APPLICATION FOR NORTH DAKOTA AUTISM WAIVER

NORTH DAKOTA DEPARTMENT OF HUMAN SERVICES
AUTISM SERVICES UNIT
SFN 60618 (10-2016)

Clear Fields

Complete as thoroughly as possible.

Today's Date

Indicate the /Service(s) You are Seeking Waiver Support For (mark all that apply)

- ☐ Program Design and Monitoring
- ☐ Skills Training
- ☐ Service Management/Family Support
- ☐ Respite Care
- ☐ Assistive Technology
- ☐ Medicaid Coverage

Name	Email Address		
Address	City	State	ZIP Code
Telephone Number	Cell Phone Number	FAX Number	
County of Financial Responsibility	Name of Tribal Affiliation		

Name of Child	Gender ☐ Male ☐ Female	Age	Height	Weight
Date of Birth	Race (optional)			
Religion (optional)				
Culture (customs, traditions, heritage, ancestry, etc.)				
Current Residence or Placement of Youth (i.e. foster home, parental home)				
Name of Foster Parent(s)/Facility		Telephone Number		
Address	City	State	ZIP Code	

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			

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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)

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

List Any Youth Living with Him/Her in the Home

Siblings

Name	Sex	Age	Relationship	Autism History

By completing this application I understand that its' contents may be shared with agencies involved in services. I have completed and attached the multi-agency release of Information for this purpose (SFN 970).

Parent/Guardian Signature	Date

Please mail, fax, or email completed application:

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

fax: 701-328-4875
email: dhsautism@nd.gov

Phone: 701-328-4630