APPLICATION FOR AUTISM VOUCHER

NORTH DAKOTA DEPARTMENT OF HUMAN SERVICES
MEDICAL SERVICES
SFN 60611 (5-2017)

Clear Fields

Voucher year: July 1, 2017 to June 30, 2018. Approved voucher requests must be initiated within the first 180 days of approval or funds will no longer be available.

APPLICANT INFORMATION

Name of Child		Gender ☐ Male ☐ Female	Age	Number of Siblings
Date of Birth	Place of Birth	Social Security Number *	Are you a U.S. citizen? ☐ Yes ☐ No	
Race (optional)		County of Financial Responsibility		
Name of Parent/Legal Guardian Child Resides With		Email Address		
Address		City	State	ZIP Code
Telephone Number	Cell Phone Number	Name of Tribal Affiliation		
Tribal Enrollment Number		If not enrolled in a tribe, is child enrollable? ☐ Yes ☐ No		

REFERRAL INFORMATION

Referral Source

- ☐ Referred by Child and Family Team/Wraparound Process
- ☐ Early Intervention
- ☐ Developmental Disabilities Division
- ☐ Pediatrician/MD
- ☐ School Personnel
- ☐ Social Service Case Management
- ☐ Other (specify): _____

Referral Reason

Identifying Need

- ☐ Sensory Need
- ☐ Accommodation
- ☐ Support for Child
- ☐ Other (specify): _____
- ☐ Support/Relief
- ☐ Caregiver
- ☐ Special Parent Training
- ☐ Travel Expense
- ☐ Special Camp
- ☐ Assistive Technology
- ☐ Educational Information

Explanation of Above-checked Areas

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 is requested for identification, income verification, and participation purposes. Failure to disclose this information will not affect your eligibility for this program. Failure to provide the information may result in delays in services.

Risk of Out-of-Home Placement Without Services

☐ Imminent ☐ High ☐ Moderate ☐ Low

Immediate Safety Concerns

INSURANCE INFORMATION

Medicaid Eligible? ☐ Yes ☐ No ☐ Unknown	Medicaid Number
Recipient Liability? ☐ Yes ☐ No ☐ Unknown	Estimated Recipient Liability/Average Per Month

Economic 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			

BEHAVIORAL ISSUES OF CONCERN

Description of Present Issues Occurring (behavior, issues or concerns)

FAMILY ORIGIN (optional)

Name of Father		Telephone Number (Home)	Telephone Number (Work)
Address		City	State / ZIP Code
Employed? ☐ Yes ☐ No	Does identified child live with? ☐ Yes ☐ No		Religion
Race	Marital Status	Age	Date of Birth

Name of Mother		Telephone Number (Home)	Telephone Number (Work)
Address		City	State / ZIP Code
Employed? ☐ Yes ☐ No	Does identified child live with? ☐ Yes ☐ No		Religion
Race	Marital Status	Age	Date of Birth

Name of Stepfather		Telephone Number (Home)	Telephone Number (Work)
Address		City	State / ZIP Code
Employed? ☐ Yes ☐ No	Does identified child live with? ☐ Yes ☐ No		Religion
Race	Marital Status	Age	Date of Birth

Name of Stepmother		Telephone Number (Home)	Telephone Number (Work)
Address		City	State / ZIP Code
Employed? ☐ Yes ☐ No	Does identified child live with? ☐ Yes ☐ No		Religion
Race	Marital Status	Age	Date of Birth

Name of Significant Other	Which Parent?
List Any Youth Living with Him/Her in the Home	

SIBLINGS

Name	Sex	Age	Address	Relationship	Autism History

DIAGNOSIS

Date	Source
Date of Most Recent Psychiatric or Psychological Evaluation	
Key Findings	

Please include with application:

1 - Current IEP or evaluation/assessment/treatment plan
2 - Diagnosis of Autism Spectrum Disorder by a professional
3 - Proof of North Dakota residency for a minimum of six months (copy of parent's driver's license, utility bill, etc.)
4 - Income verification (a full month's paystub(s) from previous month)
5 - Release of Information (SFN 1059) for school/service provider

Name	
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

phone: 701-328-4630
fax: 701-328-4875
email: dhsautism@nd.gov