APPLICATION FOR AUTISM VOUCHER

DEPARTMENT OF HEALTH AND HUMAN SERVICES
MEDICAL SERVICES
SFN 60611 (5-2023)

Clear Fields

Voucher year: July 1, 2023 to December 31, 2023. Approved voucher requests must be initiated within the first 60 days of approval or funds will no longer be available.

APPLICANT INFORMATION

Name of Child		Gender ☐ Male ☐ Female	Date of Birth	Age
Social Security Number *	Are you a U.S. citizen? ☐ Yes ☐ No	County of Financial Responsibility		

PARENT OR LEGAL GUARDIAN INFORMATION

Name of Mother or Legal Guardian	Does child reside with mother or legal guardian? ☐ Yes ☐ No		
Address	City	State	ZIP Code
Telephone Number	Email Address		
Name of Father or Legal Guardian	Does child reside with father or legal guardian? ☐ Yes ☐ No		
Address	City	State	ZIP Code
Telephone Number	Email Address		

SIBLINGS INFORMATION

Name	Sex	Age	Address	Relationship	Autism History

VOUCHER TO BE USED FOR

Respite Services	☐ Yes	☐ No
Tutoring Services	☐ Yes	☐ No
Items to assist with dealing with ASD diagnosis	☐ Yes	☐ No

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.

INSURANCE INFORMATION

Medicaid Eligible? ☐ Yes ☐ No ☐ Unknown	Medicaid Number
Is your child currently receiving any services from a Medicaid waiver? (i.e. developmental disability services) ☐ Yes ☐ No	
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			

To make a determination of application, the following must be attached:

1 - Diagnosis of Autism Spectrum Disorder by a professional - attach report
2 - Proof of North Dakota residency (copy of parent's driver's license, utility bill, etc.)
3 - Income verification (a full month's paystub(s) from previous month)
4 - Release of Information (SFN 1059) for school/service provider

Name	
Signature	Date

Please mail, fax, or email completed application:

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

Phone: 701-328-4630
Fax: 701-328-1544
Email: dhsautism@nd.gov

INTERNAL USE ONLY

Fiscal Determination	☐ Eligible ☐ Not-eligible
Waiver Enrollment Confirmed	☐ Eligible ☐ Not-eligible