APPLICATION FOR NORTH DAKOTA AUTISM WAIVER

DEPARTMENT OF HEALTH AND HUMAN SERVICES
MEDICAL SERVICES DIVISION
SFN 60618 (2-2025)

Clear Fields

Complete as thoroughly as possible.

Today's Date

*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.

Name of Child		Gender ☐ Male ☐ Female	Age	Social Security Number *
Date of Birth	Race (optional)			Telephone Number
Green Card:	Green Card Number	Year Issued		☐ N/A
Year Diagnosed with Autism Spectrum Disorder		Provider Who Made Diagnosis		
Child's Address		City	State	ZIP Code

FAMILY ORIGIN

Name of Father	Telephone Number	Email Address	
Address	City	State	ZIP Code

Name of Mother	Telephone Number	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	HSZ/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

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:

- A copy of the diagnosis from the professional who made the diagnosis of Autism Spectrum Disorder

A typed signature is legally binding and equivalent to a handwritten signature.

Parent/Guardian Signature	Date

Mail, fax or email completed application and required documents to:

Medical Services - Autism
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