Developmental Disabilities Supports Division (DDSD)
Fiscal Year 2017 (July 1, 2016 - June 30, 2017)

Autism Flexible Services Program
APPLICATION

(USE A SEPARATE APPLICATION FORM FOR EACH ELIGIBLE INDIVIDUAL
SUBMIT ALL APPLICATIONS TO DDSD)

If you have questions about the Autism Flexible Services Program or need assistance in completing this application, please contact:

- DOH/Developmental Disabilities Support Division: Sbicca Brodeur (505) 690-6942 or Joyce Solisz at (505) 476-8974 or toll Fee (877) 696-1472
- NM Autism Society: Sarah Baca (505) 332-0306
- Parents Reaching Out (PRO): Melissa Reid-Ciferri (505) 247-0192 or 1-800-524-5176
- UNM Autism Programs: Lauriann King (505) 272-1852 or 1-800- 270-1861
- Governor's Commission on Disabilities: Guy Surdi (505) 476-0420

Date of Application _____

FAMILY INFORMATION

Individual/Parent/Legal Guardian submitting the application:

_____

Relationship to individual (child / individual) _____

Mailing Address _____

_____

City _____ Zip _____

County: _____

Phone _____

Email address (if any) _____

Is it ok to leave a phone message? ❑ Yes ❑ No

CHILD / INDIVIDUAL INFORMATION

First Name: _____ Last Name: _____

Date of Birth: _____ Gender: ❑ Male ❑ Female

Race / Ethnicity: (check all that apply)

❑ Hispanic ❑ Native American ❑ Asian ❑ Black/African American ❑ White

AUTISM SPECTRUM DISORDER DIAGNOSIS

Does the child / individual have a medical diagnosis of Autism Spectrum Disorder. ❑ Yes ❑ No

Date of Diagnosis _____

Who provided the diagnosis? _____

Please attach the diagnostic report with your application*.

If you do not have a copy of the diagnostic report, please describe what are you doing to get a copy of the report? _____

*DDSD will review the report to determine that diagnosis is in accordance with the Diagnostic and Statistical Manual of Mental Disorders (DSM) and the International Classification of Disease (ICD).

FINANCIAL / BENEFIT INFORMATION

Is the child / individual enrolled in Medicaid? ❑ Yes ❑ No ❑ Don't Know

Is the child / individual on the Central Registry / waiting list for the Developmental Disabilities Waiver?

❑ Yes ❑ No ❑ Don't Know

Is the child / individual covered under a private health insurance plan that includes autism services?

❑ Yes ❑ No ❑ Don't Know

Child / Individual's Name: _____

FUNDING REQUEST FOR SERVICES

Option 1:
Applied Behavior Analysis (ABA) services – Including copayments ("copays") and deductibles up to $2,500 can be requested for each child / individual. Note: If funding for ABA is requested, support for Other Autism Services cannot be requested.

ABA Services	Name, address, email and phone # of ABA Provider	Estimated beginning date for services	Estimated end date for services	Estimated monthly costs	Amount requested (maximum of $2,500)
❑ Copay ❑ Deductible ❑ Private / Self Pay				$	$

Option 2:
Other Autism Services. See the attached "Autism Flexible Services Program - Fact Sheet" for information on services that can be funded. Up to $1,250 can be requested for each child / individual.

Specific Service/Support Requested	Name, address, email and phone # of Provider	Estimated beginning date for services	Estimated end date for services	Amount requested (maximum of $1,250)
				$
				$
				$
Total Amount Requested				$

Please use additional pages if needed.

Child / Individual's Name: _____

AGREEMENT

As the Individual / Parent / legal guardian for _____ (child / individual's name), I have reviewed this application and confirm that, to the best of my knowledge, the information provided is accurate.

I understand that funds requested in this application are to be spent of services by June 30, 2017 and will not be carried over to the following fiscal year (July 1 – June 30)

_____ _____

Signature of Individual / Parent / Legal Guardian Date

_____

Printed Name

Please submit the completed Autism Flexible Services Program application including a copy of the ASD diagnostic report by Friday, January 06, 2017 - 5:00pm.

Applications can be submitted by email, fax or mail:

Email:	DDSD.Autism@state.nm.us
Toll Free Fax:	(866) 829-8838
Mail:	Autism Flexible Services Program Child and Family Supports Bureau NM Dept. of Health / DDSD 810 W. San Mateo Santa Fe, NM 87502

FOR STATE USE ONLY:

Date Received _____

Date Application Completeness Determined _____

Application Approved ❑ Yes ❑ No Date _____

Notes: