

## Instructions for Parents/Guardian

Please fully complete the attached one page form to begin the process of applying for the Autism Waiver program.

Step 1. Section 1 requests basic information about your child and family. Personal information will be protected according to HIPPA guidelines. Please provide your child's name, date of birth, social security number (or SSN), your name as the parent or guardian, your address, a phone number by which you can be reached, and if applicable a Medicaid Identification Number. **It is the responsibility of the parent to update their contact information with KDADS if it changes after submission of the application. They can do this by contacting the Program Manager.**

Step 2. Section 2 includes two components. The first part requires you to indicate with a check mark which Autism screening tool was used in your child's diagnosis. Please check all that apply and if the screening tool is not listed, please specify which tool was used. The second part is a check list of needed items to accompany this application. Please check next to "Documentation of Autism diagnosis is attached" if you have enclosed diagnosis documentation. Please check the "Signature of licensed Medical Doctor or Ph.D. Psychologists" if a Medical Doctor or Ph.D. Psychologist has read, signed and dated the statement provided at the bottom of section 2.

Step 3.

**The form must be completed in its entirety to be eligible. The fully completed application can be submitted three ways.**

- 1) Faxed to KDADS, at 785-296-0256
- 2) Hand delivered to a local DCF office
- 3) Mailed to the New England Building:  
Attention: KDADS Autism Program Manager  
503 S. Kansas Avenue  
Topeka, KS 66603-3404

## What Happens Next?

If a child meets the criteria for the HCBS Autism Waiver, the child will receive a letter from the Autism Program Manager informing them they have been placed on the Proposed Waiver Recipient List and their numerical position on the list. When a position on the waiver becomes available the Program Manager will contact the family to offer them the potential position.

Once a child has been referred by the Program Manager for assessment, the Functional Eligibility Specialist has 5 working days to schedule a home visit and complete the functional eligibility assessment to determine if the child meets the established criteria. If the child meets the criteria, the Functional Eligibility Specialist will assist the family in completing the Medicaid application (if necessary) and refer to an Autism Specialist.

## Section 1: Child and Family Information

Child's Name: \_\_\_\_\_

Child's Date of Birth: \_\_\_\_\_ Child's SSN: \_\_\_\_\_

Parent/Guardian: \_\_\_\_\_ Parent/Guardian is Active Military:  Yes  No

Address: \_\_\_\_\_ City: \_\_\_\_\_ Zip: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Medicaid ID Number (if applicable): \_\_\_\_\_

## Section 2: Autism Spectrum Disorder Information

Documentation of Autism Spectrum diagnosis or a signature of a licensed Medical Doctor or Ph.D. Psychologist must be included at the time the application is submitted.

Please indicate with a check mark if any or all of the following is included with this application:

- Documentation of Autism Spectrum diagnosis is attached.  
 Signature of licensed Medical Doctor or Ph.D. Psychologists

Documentation was made with the aid of the following approved Autism screening tool:

- |  |   |
|--|---|
| <input type="checkbox"/> Childhood Autism Rating Scale (CARS)                | <input type="checkbox"/> Gilliam Autism Rating Scale (GARS)                 |
| <input type="checkbox"/> Autism Spectrum Diagnostic Observation Scale (ADOS) | <input type="checkbox"/> Autism Spectrum Diagnostic Interview-Revised (ADI) |
| <input type="checkbox"/> Asperger Syndrome Diagnostic Scale (ASDS)           | <input type="checkbox"/> Other (please specify below)                       |

If other please specify here: \_\_\_\_\_

This application may be submitted in one of the three following ways:

- 4) Faxed to KDADS, at 785-296-0256
- 5) Hand delivered to a local DCF office
- 6) Mailed to the New England Building:  
Attention: KDADS Autism Program Manager  
503 S. Kansas Avenue  
Topeka, KS 66603-3404

*\*Please note that the DCF Regional Office must affix a time/date stamp immediately upon receipt\**

I have made a diagnosis of an Autism Spectrum Disorder for (child's name)

\_\_\_\_\_  
Signature of Doctor

\_\_\_\_\_  
Printed Name of Doctor

\_\_\_\_\_  
Date

Please list a phone number where the above doctor can be reached:  
\_\_\_\_\_