Medicaid Autism Waiver

Request for Program Participation

**Denotes Required Field*

Child's Name: _____*

Date of Birth: _____*

Please note: In order to be eligible for services, your child's date of birth must be between January 1, 2007 and July 31, 2011

What county do you live in? _____*

Contact information:

Parent/Guardian name(s): _____*

Street Address: _____* Apartment #: _____

City: _____* State: _____ Zip: _____*

E-mail: _____

Phone number: _____*

Alternate phone number: _____

Are you submitting applications for more than one child? If so, please provide their names and dates of birth:

Child 2: _____ Date of Birth: _____

Child 3: _____ Date of Birth: _____

Does your child have an autism spectrum diagnosis (ASD) from a clinical professional, licensed to give a diagnosis? Yes ☐* No ☐

*Please note - if your child is selected to participate, you will need to provide supporting documentation within 10 days of the request. Examples of supporting documentation include: a copy of the doctor's notes, assessment results or other reports that verify the ASD diagnosis.

Does the child have assets in their name (bank accounts, trust fund, etc.) and is the balance more than $2000 at the start of each calendar month?* Yes ☐ No ☐ To be eligible for this program, only your child's assets will be considered.

☐* If my child is selected through this randomized process, I understand that I will be required to apply for Medicaid benefits with the Department of Workforce Services. All factors of eligibility must be met in order to be considered for the Medicaid Autism Waiver. Waiver Medicaid programs use different income and asset rules. If you have been denied for Medicaid in the past, your child may still be eligible for this program.

The clinician notes need to document the following:

Specific limitations in communication and social skills or behaviors such as:

- Poor social/emotional development shown by failing to communicate back and forth, share interests/emotions or begin social interactions.
- Limits in non-verbal communication. May range from poor use of body language with speech; poor eye contact to total lack of facial expression or gestures.
- Difficulty with relationships with people other than family or care-givers. May range from struggles in adjusting behavior for specific situations or imaginative play to not having any interest in other people.
- Repetitive speech, physical movements or use of objects
- Routine patterns of speech or behavior and extreme negative response to having these routines changed. May be physical movements, insisting on having the same foods or repetitive questioning on small changes.
- Unusually strong interest in specific objects or activities.
- Extremely strong or complete lack of reaction to different elements of the environment. (Not showing any reaction to pain/heat/cold, or responding very negatively to certain sounds, textures, smells, etc.) May be very interested with lights or spinning objects or constantly smelling/touching objects.

-Signs should be present in early childhood, but full effect may not be known until the child is older and unable to deal with certain situations.

-Development issues and behavior limit the ability to take care of daily tasks.

If your child has been diagnosed with ASD, but the notes from your clinician do not include many of these observations, please contact them to discuss these items.

Applications can be mailed to:

Utah Department of Health
288 N 1460 W
PO Box 143112
Salt Lake City, UT
84114-3112

Mail submissions must be postmarked from June 17, 2013 through July 12, 2013 to be considered for the program.

Applications may also be faxed to:

(801) 536-0153
Attn: Kristi H.