Iowa Autism Support Program
Application for Assistance

Part 1. Information about the child for whom you are requesting services		
Last Name:	**First Name:**	**Middle Name:**
Date of Birth (MM/DD/YYYY):	**Last 4 digits of Social Security Number:**	**County of Residence:**
Address:	**City:**	**State & Zip Code:**

☐ **Required Documentation: I have enclosed a certified copy of the child's birth certificate as proof of age.**

Part 2. Information about the child's coverage by other programs		
Please check YES or NO for each:	**YES**	**NO**
Is the child covered by Medicaid?		
Is the child covered by Medicare?		
Is the child covered by another disability plan?		
Is the child receiving any of the following Home and Community Based Waiver services:		
• **AIDS/HIV Waiver?**		
• **Brain Injury Waiver?**		
• **Children's Mental Health Waiver?**		
• **Health and Disability Waiver?**		
• **Intellectual Disability Waiver?**		

IF YOU ANSWERED "YES" TO ANY OF THE QUESTIONS ABOVE, please call DHS at 515-725-0131 for additional information before completing this application.

Part 3. Information about the child's parents or legal guardians		
Parent or Guardian #1 (primary contact person):		
Last Name:	**First Name:**	**Middle Initial:**
Date of Birth (MM/DD/YYYY):	**Phone Number with area code:**	**County of Residence:**
Address:	**City:**	**State and Zip Code:**
Please include an email address if you agree to be contacted by email:		
Email address:		

Parent or Guardian #2:		
Last Name:	**First Name:**	**Middle Initial:**
Date of Birth (MM/DD/YYYY):	**Phone Number with area code:**	**County of Residence:**
Address:	**City:**	**State and Zip Code:**

Part 4. Information about the child's medical insurance carrier	
Primary Medical Insurance Carrier:	
Member/Policy Number:	
Member/Policy Holder Name:	
Relationship to Child:	
Secondary Medical Insurance Carrier:	
Member/Policy Number:	
Member/Policy Holder Name:	
Relationship to Child:	

☐ **<u>Required Documentation</u>: I have enclosed a copy of an insurance card as proof of coverage for the child by the insurer(s) shown above.**

☐ **<u>Required Documentation</u>: I have enclosed proof of non-coverage or denial of coverage for ABA services by my primary (and secondary, if applicable) insurance carriers. This proof may be in the form of a policy document clearly specifying non-coverage for ABA services, an explanation of benefits denial, or a letter of denial from the insurer.**

Part 5. Information to determine financial eligibility	
Complete using information from the tax return where the child is claimed as a dependent:	
Most recently filed federal tax return year: **(Return must be for a tax year that ended no more than 15 months before application date.)**	
Name of tax filer and spouse, if applicable:	
Filing Status: (1) Single; (2) Married filing jointly; (3) Married filing separately; (4) Head of Household; (5) Qualifying Widow(er) **(If both parents live together and file separate tax returns, information from both returns must be included with the application.)**	

First names of persons claimed as dependents on federal Form 1040 Line(s) 6c:	
Total number of exemptions claimed on Form 1040 Line 6d:	
If a child who lives in your household is claimed as a dependent by the non-custodial parent through a release of exemption (Form 8332), enter the name of the child:	
Federal Adjusted Gross Income reported on Form 1040 Line 37 or Form 1040A Line 21:	
Amount reported on Form 1040 Line 8b (tax exempt interest (enter zero if none):	
Amount reported on Form 1040 Line 20a (Social Security benefits): (enter zero if none):	
If you filed a Form 2555 (Foreign Earned Income/Housing Exclusion), enter the amount from that form you deducted on Form 1040 Line 21 (enter zero if none):	

☐ **<u>Income Self-Attestation</u>: I attest by my signature that the income and household size information entered in Part 5 above is true and accurately represents the information reported on my federal tax return. (You do not need to attach a copy of the return.)**

Signature: _____

Part 6. Information to determine diagnostic eligibility		
Does the child have a diagnosis of autism?	**YES** _____	**NO** _____
Date of most recent diagnosis (must be within last 24 months):		
Diagnosis was made by:		
• **a child psychiatrist**	**YES** _____	**NO** _____
• **a developmental pediatrician**	**YES** _____	**NO** _____
• **a clinical psychologist**	**YES** _____	**NO** _____
Name of diagnosing professional:		
Address of diagnosing professional:		
Phone number of diagnosing professional:		

☐ **<u>Required Documentation</u>: I have enclosed a copy of all relevant medical records clearly showing a diagnosis of autism made within the last 24 months as proof of diagnostic eligibility.**

Part 7. Information on provider and service plan		
Do you need information or referral to a provider?	**YES** _____	**NO** _____
If you have identified a qualified provider, please complete the following:		
• **Provider Name:**		
• **Provider Address:**		
• **Provider Phone Number:**		
Does your provider have an established treatment plan for Applied Behavior Analysis services to the child?	**YES** _____	**NO** _____

Part 8. Information on your rights concerning Protected Health Information (PHI)

Protected Health Information (PHI) means individually identifiable information about your health or your child's health. Federal and state laws protect the privacy of your PHI. PHI cannot be shared with anyone other than your health care providers unless you give your consent. PHI may include your child's name, your name, address, and contact information. It may also include information about your child's physical and mental health and medications. If there is any health information related to HIV/AIDS, alcohol or substance abuse, or sexual, physical, or mental abuse, a specific authorization is required. A full definition of PHI is available in the federal regulations at 45 CFR §160.103. By completing and signing the information on this paper, you give DHS your permission to release any necessary PHI for your child to clinical providers, care coordination staff at Child Health Specialty Clinics' Regional Autism Assistance Program (RAP), and other entities who work with the Autism Support Program.

- **You do not have to share your information to receive assistance through the Autism Support Program.**
- **You can withdraw your consent at any time. To do so, you must tell us in writing. Mail it to: Connie B. Fanselow, Division of Mental Health and Disability Services, Iowa Department of Human Services, Hoover State Office Building, 5th Floor SE, 1305 E. Walnut Street, Des Moines, IA 50319-0014**
- **If you withdraw your consent it not take back the PHI that we have already shared, but we will not share any additional PHI.**
- **You have a right to a copy of your signed consent. Please keep a copy of this form. If you need us to supply a copy, please call 515-725-0131.**
- **If you have any questions about signing the consent, please call 515-725-0131.**

Part 9. Consent to Release Protected Health Information (PHI)		
Do you give your consent for DHS to share your child's Protected Health Information for the purposes of participation in the Autism Support Program?	**YES _____**	**NO _____**
Does your consent include HIV/AIDS information?	**YES _____**	**NO _____**
Does your consent include alcohol and substance abuse information?	**YES _____**	**NO _____**
Does your consent include sexual, physical and mental abuse information?	**YES _____**	**NO _____**
My consent ends:		
• **One year from the date of signature OR**	**YES _____**	**NO _____**
• **When my child's participation in the Autism Support Program ends**	**YES _____**	**NO _____**

I am the parent or guardian of the child identified on this application. I give my consent to process this application and for DHS to share necessary Protected Health Information for the purpose of my child's participation in the Autism Support Program as specified above.

_____ _____

Signature **Date**

_____

Printed Name

Part 10. Additional Terms of Consent for Program Participation	
Please indicate your acceptance of the conditions of participation for the Autism Support Program by placing your initials in the box to the left of each statement:	
	All information I used to complete this application and included as required documentation is true and accurate to the best of my knowledge.
	I authorize the Iowa Department of Human Services to process my application for assistance and all required documentation.
	I understand that I have 30 days from the date of application to furnish the required documents. If the application is not complete and all required documentation has not been submitted within 30 days, it will be considered incomplete and eligibility will be denied.
	I understand that if my application is denied as incomplete, I may re-apply at any time I can provide all required information and documentation.
	I understand that within 30 days of the date DHS receives my application it will be processed and I will be notified that eligibility has been approved or denied.
	I understand that all payments for services through the Autism Support Program will be paid directly to the service provider.
	I understand that I am responsible for any cost-share payments for services based on my income and agree to pay those costs directly to the service provider.

	I understand that I may request a hardship waiver of cost-share payments by furnishing additional financial information for DHS to consider.
	I understand that I am responsible for paying the provider for any services that exceed the funding limits established for my child through the Autism Support Program.
	I have received the Iowa Autism Support Program Information for Parents and Families and I understand my rights and responsibilities as an applicant and participant of the program.
	I understand that my participation in the Autism Support Program must comply with all applicable laws and regulations.

Part 11. Application checklist & submission

A complete application must include all of the following:

	APPLICATION FORM: This application, signed and dated, will all information complete.
	AGE: Copy of the child's certified birth certificate or other official proof of age.
	INSURANCE COVERAGE: Copy of both sides of your child's insurance card or other proof of insurance coverage.
	INSURANCE DENIAL: Documented proof of non-coverage or denial of coverage for ABA services from all insurance carriers.
	FINANCIAL ELIGIBILITY: All requested information and your self-attestation signature entered in Part 5.
	DIAGNOSIS: Copy of all relevant medical records clearly showing a diagnosis of autism made by a qualified professional within the last 24 months.

SUBMIT APPLICATION or questions to:

Connie B. Fanselow
Division of Mental Health and Disability Services
Iowa Department of Human Services
Hoover State Office Building, 5th Floor SE
1305 E. Walnut Street
Des Moines, IA 50319-0014
Email: cfansel@dhs.state.ia.us
Phone: 515-725-0131
Fax: 515-242-6036

Applications may be submitted by email, mail, or fax.

Part 12. What you can expect

- **You will be contacted by email or phone within three working days from our receipt of your application and informed that your application has been received, and is complete OR informed what information is missing and how you can complete the application. If information is missing, you have 30 days to complete the application. If it is not complete 30 days after submission it will be denied and you will need to start the process over when you can provide all required information and documentation.**

- **Once your application is complete, DHS will determine if you meet all the eligibility requirements for the Autism Support Program. You will receive a written notice of this decision within 30 days of your application.**

- **If your application is denied, your written notice will explain the reason why. If a change in your status occurs which you believe will make you eligible for the program, you may submit a new application at any time.**

- **If your application is approved, you will be referred to the Iowa Regional Autism Assistance Program (RAP) to set up a treatment planning conference to coordinate the services which will be covered under the Autism Support Program, and discuss any cost sharing requirements. The treatment planning call will also include the provider you have selected for services.**

- **Once a treatment plan is approved by DHS, you and your provider may begin services. The provider will be paid directly by DHS through submission of claims for completed services. It is your responsibility to pay the provider directly for any cost-sharing requirements of the program. You should work with the provider to establish the billing arrangements for those payments.**

- **Payment for services will continue to the provider for your child's covered services according to the treatment plan established for the child, and the benefit limits established for the Autism Support Program by Iowa Code Chapter 225D and Iowa Administrative Code Chapter 441-22.**

Please keep a copy of this completed and signed application for your records.