STATE OF IOWA DEPARTMENT OF
Health AND Human
SERVICES

Iowa Autism Support Program
Application for Assistance

Revised September 2024

PLEASE PRINT LEGIBILTY

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

☐ **Required Documentation: I have enclosed a copy of the child's certified 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? (Does not include *Hawk-i*)		
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 HHS at 515-201-1365 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:**	**County of Residence:**
Address:	**City:**	**State and Zip Code:**
Phone Number with area code:	**Email address:**	
Alternate Phone Number:		

Parent or Guardian #2:		
Last Name:	**First Name:**	**County of Residence:**
Address (if different from #1):	**City (if different from #1):**	**State and Zip Code:**
Phone Number with area code:	**Email address:**	
Alternate Phone Number:		

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. (Documentation of non-coverage is not required for the *Hawk-i* (Healthy & Well Kids in Iowa program as it is a state insurance program with no ABA benefit.)**

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 return tax 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; or (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 and their relationship to you:	
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:	
Tax Exempt Interest Income (Amount reported on 2020 Form 1040 if any) (enter zero if none):	
Social Security Benefits (Amount reported on 2020 Form 1040, if any) (enter zero if none):	
Foreign Earned Income/Housing Exclusion (If you filed Form 2555, enter the amount from that form you deducted on 2020 Form 1040, if any) (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. (<u>You do not need to attach a copy of the tax return</u>.)**

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:	
Name of hospital or clinic:	
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:**			
• **Provider Email:**			
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 HHS 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. If you withdraw your consent later, it does not take back any PHI that we have already shared, but we will not share any additional PHI.**
- **You can withdraw your consent at any time. To do so, you must tell us in writing. Mail it to: Iowa Autism Support Program, Division of Aging and Disability Services, Iowa Department of Health and Human Services, Lucas State Office Building, 321 E 12th St, Des Moines, IA 50319.**
- **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 515-725-3350.**
- **If you have any questions about signing the consent, please call 515-725-3350.**

Part 9. Consent to Release Protected Health Information (PHI)		
Do you give your consent for HHS 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 HHS 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 Health and Human Services to process my application for assistance and all required documentation. All information will be kept confidentially.
	I understand that I have up to 90 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 90 days, eligibility may be denied.
	I understand that if my application is denied as incomplete, or if my circumstances change, I may re-apply at any time I can provide all required information and documentation.
	I understand that within 30 days of the date HHS 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 the Program Administrator at HHS to consider.
	I understand that my family's financial eligibility will be reviewed after the first 12 months of ASP funding and that my cost share may increase or decrease at that time if my income has changed. If my family income at review has increased to above 500% of the federal poverty level, my child's eligibility for ASP funding will end.
	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.
	BIRTH CERTIFICATE: Copy of the child's certified birth certificate or other official proof of age.
	INSURANCE CARDS: Copies 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. (If your child has insurance coverage through the *Hawk-i* program and is not covered by any other insurers, the requirement for documentation of non-coverage or denial of coverage is waived.)
	FAMILY INCOME INFORMATION: All requested income information from your most recent federal tax return and your self-attestation signature entered in Part 5.
	DIAGNOSTIC REPORT: Copy of all relevant medical records clearly showing a diagnosis of autism made by a qualified professional within the last 24 months. This should include a dated full diagnostic report including the signature and professional credentials of the examining professional(s). If the original diagnosis was more than 24 months ago, supply it, along with a letter, statement, or visit summary dated within 24 months that confirms the ASD diagnosis.

SUBMIT APPLICATION or questions to: **Applications may be submitted by email or mail. All pages must be legible. Scanning is recommended.**	**Iowa Autism Support Program** **Division of Aging and Disability Services** **Iowa Department of Health and Human Services** **Lucas State Office Building** **321 E 12 St, Des Moines, IA 50319** **Email: AutismSupport@hhs.iowa.gov** **Phone: 515-725-3350 (Fax: 855-660-5915)**

Part 12. What you can expect

- **You will be contacted by email or phone within ten 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 90 days to complete the application. If it is not complete 90 days after submission it can be denied and may need to start the process over when you can provide all required information and documentation.**

- **Once your application is complete, HHS 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 the receipt of your completed application, including all required and requested documentation.**

- **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 or denied, you will be referred to the Iowa Regional Autism Assistance Program (RAP) as a resource. If you have selected a provider for ABA services, your provider will be notified so that treatment planning can begin. If you have not selected a provider, information on available providers can be supplied to you.**

- **Once a treatment plan is submitted by your provider and approved by HHS, you and your provider may begin ASP funded services. The provider will be paid directly by HHS 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.**

- **At the end of the first year of services you will be required to complete an Annual Financial Eligibility Review form to determine your child's continued eligibility for ASP services and any change in your family cost share for the second year of services.**

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