Application for ADMH Autism Services

Applicant *(*indicates required items)*:

*Name: _____
First Middle Last Preferred Name

*Address: _____
Street Address

_____
City County State Zip Code

_____
Mailing Address if different

*Telephone Number: _____ *Date of Birth: ____/____/____

*Social Security Number: _____/_____/_____ *Medicaid Number: _____

*Private Insurance: _____
(If applicable) Company Name Policy Number Group ID Number

Race/Ethnicity: _____ Gender: _____ Place of Birth: _____

Parent/Legal Guardian:

*Name: _____

*Address (*if different than above*): _____
Street Address

_____
City County State

*Relationship to applicant: _____ *Telephone Number: _____

Email: _____

Completed By *(if not completed by Client or Legal Guardian)*:

Name: _____ Date: _____

Phone Number: _____ Email: _____

Relationship: _____Applicant ____Parent ____Guardian ☐ Other: _____

*By submitting this form, I acknowledge I wish to apply for ADMH Autism Services on behalf of myself or my child. By signing this form, I give consent for eligibility review and assessment and referral to Intensive Care Coordination provider. The information disclosed pursuant to this application is protected by Federal Privacy Rules.

_____ _____
Parent/Guardian Signature Date

_____ _____
Client Signature if 14 years of age or older Date

ADMH

See page 4 for required documentation. If you need assistance with completing the application and documentation requirements, email autism@mh.alabama.gov or call 800-499-1816.

Application for ADMH Autism Services

If you need assistance completing this application or have questions, please contact the Autism Intake Specialist at autism@mh.alabama.gov or call 800-499-1816.

Name of Primary Contact, if not the Legal Guardian: _____

Address (*if different than applicant's*): _____
Street Address

_____
City County State

Relationship to Applicant: _____ Telephone Number: _____

Email: _____

Emergency Contact:

Name: _____

Relationship to Applicant: _____ Telephone Number: _____

Referral Source:

Name: _____

Telephone Number: _____ Email: _____

Additional Information:

Primary Written/Oral Language: _____Interpreter Needed: _____

Adaptive Equipment Needed: _____ Mobility Needs: _____ Hearing Impaired: _____

Visually Impaired: _____ Allergies: _____

Active/Primary Diagnoses: _____

Intellectual/Developmental Disability Diagnoses: _____

Inpatient Hospitalization/Residential Out of Home Placement:

_____

_____

Other Medical Information: _____

Physician(s): _____

_____

_____

Check (✓) ALL Services the Applicant is Currently Receiving (documentation required):

☐ Early Intervention ☐ Speech/Language Therapy ☐ Occupational Therapy

☐ Physical Therapy ☐ Behavior Supports ☐ Waiver

☐ Case Management ☐ Other

Check (✓) ALL Services the Applicant is Receiving or has Received in the last six (6) months from Other Agency(ies) (documentation required):

☐ Department of Human Resources (DHR)

☐ Department of Youth Services (DYS)

☐ Alabama Department of Rehabilitation Services (ADRS)

☐ Department of Mental Health (DMH)

☐ Alabama State Department of Education/Special Education (ALSDE) IEP or 504

If additional information is needed, the Autism Intake Specialist will contact you to request additional information. Once the completed application packet and supporting documentation is received the Autism Eligibility Specialist will contact you and/or your family to schedule a screening assessment.

Service Needs: If deemed eligible, the following services may be available through ADMH Autism Services.

Intensive Care Coordination
Behavior Supports
In-Home Therapy
Therapeutic Mentoring
Peer Support-Youth
Peer Support-Family
Psychoeducational Services

Documentation Requirements

Submit the following documentation with your application for DMH Autism Services.

You may also receive assistance with the application process by calling 800-499-1816 or emailing autism.dmh@mh.alabama.gov.

Required Documentation	
	1. Complete the application for ADMH Autism Services
	2. Submit copies of the following documents with the application:
	a. Assessment of Autism Spectrum Disorder (Psychological Evaluation, Adaptive Skills testing, diagnostic report, Autism Diagnostic Tool for Healthcare Providers)
	b. Most recent physical/well visit screening
	c. Copy of Guardianship or Custody documents if applicable (DHR, Divorce Decree, Guardianship documentation, etc.)
	d. Notice of Privacy (requires signature)
Optional Documentation	
	e. Copy of reports describing the disability completed by schools attended or other services agencies (e.g., IEP, IFSP, 504 Plan, Speech/Language Report etc.)
	f. Copy of reports documenting involvement of child-serving agencies such as DHR, DYS, ADRS etc.
	g. Copy of discharge summary from inpatient/residential placement if applicable
	h. Authorization for Release of Information (requires signature) if you would like us to request/release records and or information from a specific agency
	i. Copy of Medicaid Card
Return the application and requested documents to: autism@mh.alabama.gov or ADMH Autism Services, 100 North Union Street, Suite 350, Montgomery, AL 36130-1410	

Once it is determined that all necessary documentation has been received, you will be contacted by the Eligibility Specialist to schedule a screening assessment.

Please return this application and all supporting documentation to:

autism@mh.alabama.gov

or

ADMH Autism Services
100 North Union Street, Suite 350
PO Box 301410
Montgomery, AL 36130

The information disclosed pursuant to this application is protected by Federal Privacy Rules.