Application Request Form

The Renewal Autism Waiver Program

The Autism Division of the Department of Developmental Services

Child's Information (please print or type)

Name of Child	
Child's Date of Birth	☐☐ ☐☐ ☐☐☐☐ Month Day Year
Child's Social Security #	☐☐☐ ☐☐ ☐☐☐☐
For Children Age 3:	Is your child transitioning out of Early Intervention (Circle) Yes No
Child's Gender	☐ Female ☐ Male
Mailing Address	
City	
State	
ZIP Code	
Name of Parent/Guardian	
Spoken Language Preference	
Written Language Preference	

Diagnostic Information:

Does the child have a verified diagnosis of an Autism Spectrum Disorder? ☐ **YES** ☐ **NO**

If YES, what is the diagnosis? (Check one):

☐ Autistic Disorder ☐ Pervasive Developmental Disorder – Not Otherwise Specified (PDD-NOS)

☐ Childhood Disintegrative Disorder ☐ Rhett's Syndrome OR ☐ Asperger's Syndrome

☐ Please list other related medical, cognitive or psychiatric conditions affecting your child:

MassHealth Information:

Does your child currently receive MassHealth (MH) Standard Benefits? ☐ YES ☐ NO

If yes, please provide your child's MassHealth ID Number found on his or her MassHealth Card:

Account # ☐☐☐☐☐☐☐☐☐☐

Enrollment Instructions:

- **All Forms must have a Postmark or Date Stamp between September 20th – October 1st.**
- Remember to complete the entire form
- Please print and sign using a pen
- Only one application per child is acceptable; DDS will discard any duplicate applications
- You must complete your application in the 12 day open application period for consideration for the eligibility process for the Renewal Autism Waiver Program
- Please mail your application to:
  DDS Autism Division, Att. Autism Renewal Waiver, 500 Harrison Ave, Boston, MA 02118

I have completed this form accurately and truthfully to the best of my knowledge.

Signature: **Date:**