



# ATAP

Aging and Disability Services Division

Please fax or email completed form to:  
ATTN-ATAP Intake (775) 687-0119 or  
[adsdatap@adsd.nv.gov](mailto:adsdatap@adsd.nv.gov)

## Referral to Autism Treatment Assistance Program (Please attach completed assessment results and copy of current I.F.S.P.)

<b>Autism Diagnosis Date:</b>			
<b>Parent/Child Contact Information</b>			
Child's Name:		Translator Needed:	
Date of Birth:	Child's Age:	Gender:	Race:
Home Address:			
Parent/Guardian #1:		Phone Number:	
Parent/Guardian Email Address:			
Parent/Guardian #2:		Phone Number:	
Primary Language:			

<b>Referral Source Contact Information</b>		
Referring Agency:		Date that Referral was made:
Contact Name:		
Office Phone:	Office Fax:	Email:

<b>Insurance &amp; Medicaid Information</b>		
Primary Insurance:		Secondary Insurance:
Medicaid? Yes:    No:	Type of Medicaid:	Medicaid Number:

<b>Consent</b>	
<input type="checkbox"/> I give my permission for my provider to refer my child to the Autism Treatment Assistance Program.	
<input type="checkbox"/> I have been provided information on the Autism Treatment Assistance Program and I decline a referral.	
Parent Signature:	Date: