Aging and Disability Services Division

Autism Treatment Assistance Program

Application for Autism Treatment Assistance Program

Your child must have a diagnosis of autism spectrum disorder (ASD) to process your application. The completed application can be returned in-person, faxed or mailed to the address below:

ATAP Office Locations			
☐ CARSON CITY	☐ ELKO	☐ LAS VEGAS	☐ RENO
1550 E. College Pkwy. Carson City, NV 89706 Phone:(775) 687-0113 Fax:(775) 687-0119	1020 Ruby Visit Drive, Suite 102 Elko, NV 89801 Phone:(775) 687-0113 Fax:(775) 687-0119	7150 Pollock Drive Las Vegas, NV 89119 Phone:(702) 688-3271 Fax:(702) 668-3299	10375 Professional Cr. Reno, NV 89521 Phone:(775) 687-0113 Fax:(775) 687-0119

Autism Diagnosis Date:

Applicant Information

Child's Name:	Primary Language of Child:
Date of Birth (MM/DD/YY):	Child's Age:

Race/Ethnicity

☐ American Indian/Alaskan Native	☐ Black/African American	☐ Middle Eastern/North African
☐ Asian	☐ Caucasian/White	☐ Native Hawaiian/Pacific Islander
☐ Bi-racial/multi-racial	☐ Filipino	☐ I choose not to answer
	☐ Hispanic/Latino	☐ Unknown

Nevada Resident: ☐ Yes ☐ No

Home Address: (Street, City, State, Zip Code)

Mailing Address: (Street, City, State, Zip Code)

Primary Parent/Guardian Name (If Applicable):	Primary Language of Parent/Guardian:
Phone Number:	Email Address:
Secondary Parent/Guardian name (If Applicable):	Language of Secondary Parent/Guardian:
Phone Number:	Secondary Parent/Guardian Email Address:

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Child's Name (First, Last):				
This information is used to comply with state law NRS 239B.022- 239B.026 Only the Department of Human Services will have access to this information. Providing this information is optional.				
Sex Assigned at Birth:	Gender Identity:		Sexual Orientation:	
☐ Male ☐ Female ☐ Prefer not to disclose	☐ Male ☐ Female ☐ Transgender Male ☐ Transgender Female ☐ Genderqueer/gender non-conforming ☐ Not listed (specify) ☐ Prefer not to disclose		☐ Heterosexual ☐ Homosexual ☐ Bisexual ☐ Not listed (specify) ☐ Prefer not to disclose	
Name of School:				
Student has:	☐ Individualized Education Plan (IEP)	☐ 504 Plan	☐ Behavioral Intervention Plan	☐ Multidisciplinary Team Plan (MDT)
Additional Services				
Other services or programs provided (Applied Behavior Analysis, Nevada Early Intervention Services, Therapies, Physicians, Psychologist, Regional Centers, etc.):				
Developmental Specialist/Case Manager Name (First, Last Name):				
Types of services and support you need:				
Insurance & Medicaid Information				
☐ Medicaid ☐ Managed Care Organization ☐ Katie Beckett ☐ Nevada Check-Up				
Medicaid ID Number:				
☐ Private Insurance	Insurance Name:	Insurance ID: (if available)		
☐ Dual Coverage	Specify Dual Coverage:			

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☐ No Insurance	Notes about No Insurance:

Applicant/Child's Insurance Status:
☐ Insured ☐ Seeking Insurance ☐ Uninsured ☐ Underinsured ☐ Other

If "Other" Please Specify:

Current Medical Diagnosis'**:**

Availability

Please list your preferred day(s) and times of week for therapy services.

I understand this is a preferred schedule and my service hours may be based on the provider's availability within these times. ☐ Yes ☐ No

Monday	Tuesday	Wednesday	Thursday	Friday	Saturday	Sunday
Ex. 9-12	5-7	9-5	12-7	12-7	None	None

Number of days per week:	Number of hours per day:	Total hours per week:

Consent

I am requesting services from the Autism Treatment Assistance Program. ATAP is a state program that helps people in Nevada with obtaining services for Autism. I understand that I can cancel this request at any time. I also understand that the information ATAP collects will be kept private. By signing this form, I agree to provide all the information needed to see if I am eligible. ATAP will deny my application if they lose contact with me, don't get the information needed, or I am not eligible.

(Applicant Signature)	(Date)
(Parent/Guardian Signature [if applicable])	(Date)

Clear Form