Aging and Disability Services Division
Autism Treatment Assistance Program

Application

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 Vista Drive Suite 102 Elko, NV 89801 Phone: (775) 687-0113 Fax: (775) 687-0119	7150 Pollock Drive Las Vegas, NV 89119 Phone: (775) 687-0113 Fax: (775) 687-0119	10375 Professional Cr. Reno, NV 89521 Phone: (775) 687-0113 Fax: (775) 687-0119

ATAP Diagnosis Date:

Applicant Information

(Child's First, Last Name)	(Primary Language of Child)	(Primary Language of Parent)
(Child's Date of Birth)	(Child's Age)	(Primary Language of Parent)
Race/Ethnicity: ☐ American Indian/Alaskan Native ☐ Asian ☐ Bi-racial/multi-racial	☐ Black/African American ☐ Caucasian/White ☐ Filipino ☐ Hispanic/Latino	☐ Middle Eastern/North African ☐ Native Hawaiian/Pacific Islander ☐ I choose not to answer ☐ Unknown
Child's citizenship status: ☐ United States Citizen ☐ Qualified Alien Status	☐ Nevada Resident	Social Security Number

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

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

Parent/Guardian Information

Primary	Secondary
(First, Last Name)	(First, Last Name)
(Phone Number)	(Phone Number)
(Email Address)	(Email Address)

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Parent's citizenship status:
☐ United States Citizen ☐ Nevada Resident Social Security Number
☐ Qualified Alien Status

This information is used to comply with state law NRS 239B.022- 239B.026 Only the Department of Human Services (DHS) will have access to this information. Providing the information is optional.

Sex Assigned at Birth:	Gender Identity:	Sexual Orientation:
☐ Male	☐ Male	☐ Heterosexual
☐ Female	☐ Female	☐ Homosexual
☐ Prefer not to disclose	☐ Transgender Male	☐ Bisexual
	☐ Transgender Female	☐ Not Listed (specify):
	☐ Genderqueer/Gender non-conforming	☐ Prefer not to disclose
	☐ Not Listed (specify):	
	☐ Prefer Not to Disclose	

Name of School (if applicable):

Student has: ☐ Individualized Education Plan (IEP) ☐ 504 Plan ☐ Behavioral Intervention Plan ☐ Multidisciplinary Team Plan

Additional Services

Other Services or Programs Provided (Applied Behavior Analysis, Nevada Early Intervention Services, Therapies, Physicians, Psychologist, Developmental Services, etc.):

Developmental Specialist/Case Manager Name (First, Last Name):

Types of services and supports you need:

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Insurance and Medicaid Information

☐ Medicaid ☐ Managed Care Organization ☐ Katie Beckett Medicaid ☐ Nevada Check-Up

Medicaid ID Number:

☐ Private Insurance Insurance Name (if applicable): Insurance ID (if available):

☐ Dual Coverage Specify Dual Coverage:
☐ No Insurance Coverage Notes about No Insurance:

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 [if not parent/guardian]) (Signature Date)

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

Clear Form