ATAP
Aging and Disability Services Division

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

Referral to Autism Treatment Assistance Program

(Please attach completed assessment results and copy of current I.F.S.P.)

Autism Diagnosis Date:			
Parent/Child Contact Information			
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:			

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

Insurance & Medicaid Information		
Primary Insurance:		Secondary Insurance:
Medicaid? Yes: No:	Type of Medicaid:	Medicaid Number:

Consent	
☐ I give my permission for my provider to refer my child to the Autism Treatment Assistance Program. ☐ I have been provided information on the Autism Treatment Assistance Program and I decline a referral.	
Parent Signature:	Date: