Autism Spectrum Fund (ASF) Application Form

Mental Health Association in Orange County, Inc.
73 James P. Kelly Way, Middletown NY 10940

Phone-(845) 342-2400 ext 1235/1253
Fax- (845)343-9665
Print additional forms at www.mhaorangeny.com

Date_____

Name of individual with disability _____

Address_____

City_____**State**_____**Zip Code**_____**E-mail**_____

Telephone_____**Birth date**_____**Gender**_____

Social Security Number_____-_____-_____ **Tabs #** _____

Referring service provider/Coordinator_____**Agency**_____

Phone_____**E-mail** _____

Parent/family contact name_____**Relationship**_____

Telephone other than home_____**E-mail** _____

Lives with parent/guardian Y____**N**____

Developmental disability (circle all that apply and add notes or specify below if needed)

Autism/P.D.D. **Cerebral Palsy** **Epilepsy** **Intellectual/Developmental Disability**

Neurological impairment(specify)_____

Medicaid _____ **SSI** _____ **SSA**_____ **Private health insurance**_____
Day program/school _____

Goods/services requested_____

If reimbursement requested, to whom will the check be made out:

Name_____**Phone** _____

Address_____

City_____ **State** _____ **Zip** _____

Have you made this request to any other program or service? Yes_____ **No**_____

Specify programs/services contacted_____

What was the outcome?_____

How will the service or item benefit the person with a disability or the family:_____

_____

Additional information you want us to know about the request:_____

_____

Mental Health Association
in Orange County, Inc.

NADIA ALLEN, EXECUTIVE DIRECTOR

Autism Spectrum Fund (ASF)

In order for your **initial** Autism Spectrum Fund (ASF) application to be processed you will need to submit items ***1 through 4.***

1) Completed application form, printed or typed clearly!

2) 2) HIPAA ("Notice of Privacy Practice and Program Participants Rights")
Click here for HIPAA forms Signature page filled out, signed and dated.

3) Verification of Autism Spectrum Disorder:

- A diagnostic report from a MEDICAL DOCTOR. Be aware that reports from psychologists, nurse practitioners or school psychologist will not be accepted!

or

- Notice of Decision (NOD) from Hudson Valley DDRO.

4) Invoice, receipts, price list or brochure for the services/goods requested and vendor contact information.

*For future applications, submit items 1and 4. Please call 845-342-2400 ext. 1235 or 1253 for further information or questions.

73 JAMES P. KELLY WAY * Middletown, NEW YORK 10940 * (845) 342-2400-FAX (845) 343-9665
EBEN ROCKWELL HILL, PRESIDENT * A UNITED WAY AGENCY