

| YOUR CHILD'S INFORMATION | | | |
|--------------------------|-----------------------|------------------------------|-------------------------------|
| Child's Surname: | | Child's First Name: | |
| Child's D.O.B: | Year of school entry: | <input type="checkbox"/> Boy | <input type="checkbox"/> Girl |

| FAMILY INFORMATION | |
|--|---|
| Residential Address: _____ _____ _____ | Email Address*: _____ Do you wish to receive our electronic newsletter (eSpectrum) for regular updates about any changes to the HCWA package and related information from Autism Victoria? <input type="checkbox"/> YES <input type="checkbox"/> NO <input type="checkbox"/> ALREADY SUBSCRIBED |

** You must provide a valid email address to receive monthly activity statements outlining your child's remaining funding allocation. If you do not have an email address, please be aware your balance statements will be delayed.*

| | | | |
|--------------------------------|---------------------------------|---------------------------------|--------------------------------------|
| Primary Contact's Name: | _____ | | |
| Relationship to Child: | <input type="checkbox"/> MOTHER | <input type="checkbox"/> FATHER | <input type="checkbox"/> Other _____ |
| Phone: | (H) _____ | (M) _____ | (W) _____ |

| | | | |
|-------------------------------|---------------------------------|---------------------------------|--------------------------------------|
| Other Contact's Name: | _____ | | |
| Relationship to Child: | <input type="checkbox"/> MOTHER | <input type="checkbox"/> FATHER | <input type="checkbox"/> Other _____ |
| Phone: | (H) _____ | (M) _____ | (W) _____ |

| Please complete details about other children in the family: | | | |
|---|----------------|-------|-----------------------------------|
| | Sibling's Name | D.O.B | Does this child also have an ASD? |
| Sibling 1: | | | YES NO |
| Sibling 2: | | | YES NO |
| Sibling 3: | | | YES NO |
| Sibling 4: | | | YES NO |

| TYPE OF APPOINTMENT PREFERRED | |
|---|---|
| <input type="checkbox"/> TELEPHONE CONSULTATION | <input type="checkbox"/> FACE-TO-FACE CONSULTATION* <i>*Please note we cannot do home visits</i> |

| ETHNICITY AND RESIDENCY | |
|---|---|
| Is your child of Aboriginal or Torres Strait Islander descent? | <input type="checkbox"/> YES <input type="checkbox"/> NO |
| What is your child's country of birth*? | |
| <i>*If your child was born outside Australia, please attach proof of Australian citizenship or permanent residency</i> | |
| What is your child's residency status? | |
| <input type="checkbox"/> Australian Citizen <input type="checkbox"/> Permanent Resident <input type="checkbox"/> Other (please specify) _____ | |
| Main language spoken at home: | If English is not your first language, do you require an interpreter? |
| | <input type="checkbox"/> YES <input type="checkbox"/> NO |

| SERVICE INFORMATION | | |
|---|-----------------------------|--|
| Please outline the services your child is currently attending (if any). | | |
| Service/Therapy | Program Provider/Therapist? | Is provider on FaHCSIA's approved panel? |
| | | YES NO UNSURE |
| | | YES NO UNSURE |
| | | YES NO UNSURE |
| | | YES NO UNSURE |

| OTHER CONDITIONS |
|--|
| Does your child have any conditions in addition to an Autism Spectrum Disorder that will be considered in relation to their early intervention program? |
| <input type="checkbox"/> Epilepsy <input type="checkbox"/> Intellectual Disability |
| <input type="checkbox"/> Attention Deficit (Hyperactivity) Disorder (ADD/ADHD) <input type="checkbox"/> Global Developmental Delay |
| <input type="checkbox"/> Other _____ |

| INFORMATION FOR STATISTICAL PURPOSES |
|---|
| How did you first hear about the Autism Advisor Program? |
| <input type="checkbox"/> Autism Victoria or other State Autism Association <input type="checkbox"/> Other autism/disability organisation |
| <input type="checkbox"/> Playgroups Australia and/or Playgroups (PlayConnect) <input type="checkbox"/> Medical Practitioner (Psychiatrist, Paediatrician, GP) |
| <input type="checkbox"/> State/territory government service <input type="checkbox"/> Childcare/preschool/education |
| <input type="checkbox"/> FaHCSIA/HCWA website, workshops, inquiry line <input type="checkbox"/> Friend/relative/other parent |
| <input type="checkbox"/> Allied health professional and/or Multi-disciplinary team (Psychologist, Speech therapist, Occupational therapist) |
| <input type="checkbox"/> Other _____ |

ASSISTANCE WITH ACCESS

Did somebody else help you to fill in this form? YES NO (please go to the next section)

Do we have permission to talk to this person, if necessary? YES NO

If Yes, please include this person's contact details:

| | |
|--|--|
| Name: | |
| Relationship to family: (e.g. case worker, relative, friend) | |
| Phone Number: | |

CONSENT TO CONTACT PROFESSIONALS

The Autism Advisors may need to contact the professionals who diagnosed your child to clarify aspects of the diagnosis or to ask them to send more information. This will allow the Advisors to process your child's application more quickly. Do you give permission for the Advisors to do this (please tick and sign)

YES NO

Signed: _____

Date: _____

CONSENT TO PROCESS APPLICATION

I, _____ (parent/guardian name) give Autism Victoria permission to enter and access the details for my child, _____ (child's name) on the FaHCSIA Financial Management System. The information I have provided is true and correct.

Signed: _____

Date: _____

APPLICATION CHECKLIST

I have enclosed copies of:

- My child's birth certificate
- A rates notice or utilities bill with my current address
- My child's Centrelink Reference Number (CRN – the number on his/her Health Care Card)
- A report or letter signed by a paediatrician, psychiatrist or multi-disciplinary team stating my child's diagnosis
- If the child was born overseas, proof of Australian citizenship or permanent residency.
- I have signed the consent boxes above.

Once complete, please send this form along with all supporting documentation to:
Autism Advisor Program, Autism Victoria, PO Box 374, Carlton South 3053