

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? YES NO

What is your child's country of birth*? _____

**If your child was born outside Australia, please attach proof of Australian citizenship or permanent residency*

What is your child's residency status?

Australian Citizen Permanent Resident Other (please specify) _____

Main language spoken at home:

If English is not your first language, do you require an interpreter?

YES 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

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?

- Epilepsy Intellectual Disability
- Attention Deficit (Hyperactivity) Disorder (ADD/ADHD) Global Developmental Delay
- Other _____

INFORMATION FOR STATISTICAL PURPOSES

How did you first hear about the Autism Advisor Program?

- Autism Victoria or other State Autism Association Other autism/disability organisation
- Playgroups Australia and/or Playgroups (PlayConnect) Medical Practitioner (Psychiatrist, Paediatrician, GP)
- State/territory government service Childcare/preschool/education
- FaHCSIA/HCWA website, workshops, inquiry line Friend/relative/other parent
- Allied health professional and/or Multi-disciplinary team (Psychologist, Speech therapist, Occupational therapist)
- 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