Autistic Disorder Confirmation, DSHS 13-905
Instructions

Dear Applicant:

Please see the instructions below regarding use of the Autistic Disorder Confirmation form, DSHS 13-905.

- This form should be provided to the clinician that provided your DSM-5 evaluation and diagnosis for completion. However, per WAC 388-823-0500, any of the below professionals can complete and sign the Autistic Disorder Confirmation form:

  (a) Board certified neurologist;
  (b) Board certified psychiatrist;
  (c) Licensed psychologist;
  (d) Licensed physician associated with an autism center, developmental center, or center of excellence;
  (e) Advanced registered nurse practitioner (ARNP) associated with an autism center, developmental center, or center of excellence; or
  (f) Board certified developmental and behavioral pediatrician.

- Per WAC 388-823-0500 and 388-823-0510, this form can be used as documentation of a qualifying diagnosis in the category of Autism if you have (1) and (2) below. The diagnosis must include a diagnostic report that includes documentation of the diagnostic criteria specified in the DSM-5.

  1. An evaluation and diagnosis of autism spectrum disorder 299.00 per the Diagnostic and Statistical Manual of Mental Disorders, fifth edition (DSM-5), with a severity level of 2 or 3 in both columns of the severity level scale, and
  2. A FSIQ score of one standard deviation below the mean or higher as described in WAC 388-823-0720.

- **This form alone is NOT adequate to document a diagnosis of Autism consistent with WAC 388-823-0500.** DDA must also receive documentation of the items listed above to consider this form as evidence.

The form is available by contacting any of the below offices and asking to speak with an eligibility supervisor or case manager and by download at the below website:

Region 1 Headquarters (**Counties served:** Adams, Asotin, Benton, Chelan, Columbia, Douglas, Ferry, Franklin, Garfield, Grant, Kittitas, Klickitat, Lincoln, Okanogan, Pend Oreille, Spokane, Stevens, Walla Walla, Whitman, Yakima)
1611 W INDIANA AVE SPOKANE WA 99205-4221
Toll Free: 1-800-462-0624

Region 2 Headquarters (**Counties served:** Island, King, San Juan, Skagit, Snohomish, Whatcom)
20311 52ND AVE W STE 302 LYNNWOOD WA 98036-3901
Toll Free: 1-800-788-2053

Region 3 Headquarters (**Counties served:** Clallam, Clark, Cowlitz, Grays Harbor, Jefferson, Kitsap, Lewis, Mason, Pacific, Pierce, Skamania, Thurston, Wahkiakum)
1305 TACOMA AVE S STE 300 TACOMA WA 98402-1903
Toll Free: 1-800-248-0949

- For more information about DDA Eligibility, go to https://www.dshs.wa.gov/dda/consumers-and-families/eligibility

Washington State Department of Social & Health Services
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DEVELOPMENTAL DISABILITIES ADMINISTRATION (DDA)

Autistic Disorder Confirmation

The DDA, per WAC 388-823-0500, continues to require that applicants meet criteria for a DSM-IV-TR diagnosis of Autistic Disorder (299.00). We have received a report from you or your clinic, which includes a diagnosis of Autism Spectrum Disorder (299.00) per the DSM-5. Your completion of this form will assist us to finalize an eligibility determination for the applicant named below. **Note: This form alone is not adequate to document a diagnosis of autism consistent with DDA WAC 388-823-0500.**

NAME	DATE OF BIRTH	CLINICIAN *	DATE OF REPORT

* (WAC 388-823-0500 requires that the diagnostician be a neurologist, psychiatrist, licensed psychologist, developmental and behavioral pediatrician, or Advanced Registered Nurse Practitioner (ARNP) associated with an autism center or developmental center.)

_____ demonstrated impairments in social interaction, social communication, and behavior consisted with Autistic Disorder (DSM-IV-TR code 299.00).

_____ exhibits the following DSM-IV-TR criteria (<u>total of six or more</u>).

Please list two or more specific, current examples of qualitative impairments in social interactions:

Please list one or more specific, current examples of qualitative impairments in communication:

Please list one or more specific, current examples of impairment related to restricted, repetitive, and stereotypical patterns of behavior, interests, and activities:

The following delays / abnormal functioning were evident prior to age three (3) in the following areas:

CLINICIAN DATE

This document must be signed and dated by the clinician cited above.
Please return this document via mail, fax, or scan to:

WORKER'S NAME		PHONE NUMBER (AREA CODE)	FAX NUMBER (AREA CODE)
MAILING ADDRESS	CITY STATE ZIP CODE		EMAIL ADDRESS

If this review was completed by a DDA psychologist, please sign and date here:

SIGNATURE	DATE	PRINT NAME HERE	PHONE NUMBER (AREA CODE)