



The personal information collected on this form will be used for the purpose of providing funds through Autism Funding Programs: Ages 6-18 Program under the authority of the Supply Act and guided by the Freedom of Information and Protection of Privacy Act. Any questions about the collection, use or disclosure of this information should be directed to the Children and Youth Special Needs Policy Branch, 250-952-6044, PO Box 9719 Stn Prov Govt, Victoria, B.C. V8W 1C3.

Instructions: See page 4 of the Autism Funding Agreement. (CF0902) AGREEMENT NUMBER: _____

MONTH: _____ YEAR: _____

Form with fields for CHILD'S LAST NAME, FIRST, MIDDLE, and BIRTH DATE (YYYY/MM/DD)

1. SERVICES PURCHASED

Table with 5 columns: NAME & ADDRESS OF SERVICE PROVIDER, TYPE OF SERVICE, DATE(S) OF SERVICES PROVIDED, AMOUNT, DATE OF PAYMENT (YYYY/MM/DD)

TOTAL AMOUNT PAID []

2. OTHER AUTISM EXPENSES (Travel, Training, Equipment and Materials)

Table with 4 columns: TYPE OF PURCHASE*, NAME AND DATE OF ITEM/CONFERENCE/TRAINING PURCHASED OR PURPOSE OF TRAVEL EXPENSE, AMOUNT, DATE OF PAYMENT (YYYY/MM/DD)

*Type of purchase refers to Travel, Training, Equipment or Materials as outlined within "A Parent's Handbook: Your Guide to Autism Programs".

TOTAL AMOUNT PAID []

Original detailed expense receipts or invoices with proof of payment attached

Bank statement for each month attached

I understand that I can claim only for eligible expenses as outlined in A Parent's Handbook: Your Guide to Autism Programs and that the above listed expenses were incurred on behalf of my Child named above for Autism Intervention.

Form with fields for PARENT'S NAME (Please Print), DAYTIME PHONE NUMBER, PARENT'S SIGNATURE, DATE SIGNED (YYYY/MM/DD)

Mail Completed Schedule B and Original Receipts to: AUTISM FUNDING UNIT, MINISTRY OF CHILDREN AND FAMILY DEVELOPMENT, PO BOX 9776 STN PROV GOVT, VICTORIA BC V8W 9S5, Toll Free: 1-877-777-3530 or In Greater Victoria: 250-387-3530