



The personal information collected on this form will be used for the purpose of providing funds through Autism Funding Programs: Under Age 6 Program and 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.

Under the Autism Invoice Payment Option, a parent or guardian uses this form to indicate services or other eligible expenses that will be paid for out of the child's autism account. Please read page 2 carefully before completing this form. Parent or Guardian fills out Part A and/or Part B.

SECTION 1 PARENT/GUARDIAN INFORMATION

Form with fields: LAST NAME (FIRST, MIDDLE), HOME PHONE NUMBER, WORK PHONE NUMBER, ADDRESS, CITY/TOWN, POSTAL CODE

SECTION 2 CHILD INFORMATION

Form with fields: LAST NAME (FIRST, MIDDLE), DATE OF BIRTH (YYYY/MM/DD), Is this a child in care? (Yes/No)

PART A SERVICES

Complete this section to authorize payment to a service provider who is providing autism intervention for the child.

Form with fields: SERVICE PROVIDER NAME, AGENCY NAME (If Applicable), ADDRESS, CITY/TOWN, POSTAL CODE, PHONE NUMBER, PAYMENT TO BE PROVIDED TO (Check one): SERVICE PROVIDER, AGENCY, TYPE OF SERVICE(S), FROM: YYYY/MM/DD, TO: YYYY/MM/DD, FEE, PER (HR./DAY), TOTAL AMOUNT

PART B ADDITIONAL EXPENSES: Travel, Training, Equipment, and Supplies

Complete this section to authorize payment to a supplier for expenses related to travel, training, equipment or materials directly on behalf of a parent or guardian.

Form with fields: SUPPLIER NAME, CONTACT PERSON, PHONE NUMBER, ADDRESS, CITY/TOWN, POSTAL CODE

Table with 2 columns: PLEASE PROVIDE DETAILED DESCRIPTION, ITEM COST. Includes a large arrow pointing to a box labeled TOTAL.

I consent to use the child's autism funding for up to the total amount for services or other purchases noted on this form.

Form with fields: SIGNATURE OF PARENT/GUARDIAN, DATE SIGNED (YYYY/MM/DD)

MAIL OR FAX COMPLETED FORM 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

FAX NUMBER: 250-356-8578

INSTRUCTIONS ON COMPLETING THE CF0925 REQUEST TO PAY SERVICE PROVIDERS/SUPPLIERS

1. Parents must use funding for eligible autism intervention services, as outlined *A Parent's Handbook: Your Guide to Autism Programs*.
2. Parents should ask service providers to confirm their hourly rate(s) and any other expenses (i.e. report writing, meetings).
3. Parents complete **Part A** of this form to authorize payment to the service provider.
4. Parents should sign invoices/bills for services provided to their child. The service provider must mail, email or fax the invoice to the Autism Funding Unit to receive payment.
5. Parents complete **Part B** of this form to authorize payment to a supplier/company for travel, training, equipment or supplies. Parents may spend up to 20% of total annual funding on eligible, travel, training, equipment and supplies related to intervention, as outlined in *A Parent's Handbook: Your Guide to Autism Programs*.
6. If the service provider wishes to be paid by direct deposit into their account, the Autism Funding Unit can provide them with a direct deposit form.
7. The Provincial Government is GST exempt. Service providers should not include GST in their billings.

Contact the Autism Funding Unit for information on completing this form

Phone: within Victoria: 250-387-3530 or toll-free: 1-877-777-3530

Email: mcf.autismfundsprocessingunit@gov.bc.ca