

# Autism Spectrum Disorder Individualized Funding (ASD IF) Application form

## Instruction on How to Apply

Before filling out the application, please read the instructions below carefully:

- **To qualify, child must meet all of the following eligibility requirements:**
  - Is a resident of Saskatchewan
  - Is under six years old  
**Please note:** If your child has recently turned 6, please contact [autismif@gov.sk.ca](mailto:autismif@gov.sk.ca).
  - Has been diagnosed with Autism Spectrum Disorder (ASD)
  - Is not ordinarily resident on an Indian reserve as defined in the Indian Act (Canada).  
If your child ordinarily resides on an Indian reserve as defined in the Indian Act (Canada) your child may be eligible to access similar benefits provided by the Federal Government. If your child is eligible to receive benefits provided by the Federal Government then your child is not eligible for ASD IF. Please call 1-866-885-3933 (Government of Canada) or 1-833-304-1774 (Government of Saskatchewan Autism IF toll free line) for more information.
- **Legal Guardians, Persons of Sufficient Interest and specified Other caregivers may apply for ASD IF on behalf of the child:**
  - **Parent means:** the biological or adoptive mother or father of a child
  - **Legal Guardian means:** a person to whom custody of a child has been granted by a court of competent jurisdiction or by a deed or agreement of custody
  - **Persons with Sufficient Interest means:** Person having a sufficient interest; holds legal custody and is designated by the court to be a person having a sufficient interest in a child pursuant to section 23 of the Child and Family Services Act
  - **Other means:**
    - A person with whom the child resides who is the primary caregiver and is not a legal or natural guardian but who is raising the child (i.e. grandparent, aunt)
    - Documentation for verification of Other caregiver will be requested from the ASD IF administration office after the application has been reviewed.
- **Please ensure you submit the following documentation, where applicable, along with your completed application:**
  - Proof of Saskatchewan Residency - *SGL Licence or utility bill from within the last 3 months*
  - Child's birth certificate
  - Proof of ASD diagnosis
    - If your child has received their ASD diagnosis **before** July 1, 2018 and you have provided consent to your ASD diagnostic team or ASD consult to share this information you do not need to include any proof of diagnosis as the Saskatchewan Health Authority will confirm diagnosis upon application. If you have not provided consent to share this information prior to July 1, 2018, you will need to provide the completed Diagnosis of Autism Spectrum Disorder form that has been signed by a Qualified Specialist. This form is available on the Saskatchewan.ca website.
    - If your child has received their diagnosis **after** July 1, 2018, you will need to submit the completed Diagnosis of Autism Spectrum Disorder form that has been signed by a Qualified Specialist.
  - [Direct deposit form](#) (if preferred option)
  - For Legal Guardians and Persons with Sufficient Interest only: court documentation required.

Once you have completed your application, please mail this form and the required documents to below address:

Autism Spectrum Disorder Individualized Funding  
Box 1300  
Moose Jaw, SK S6H 4R2



### Parent/Guardian Information

<b>First Name:</b>	<b>Middle Name:</b>
<b>Last Name:</b>	
<b>Social Insurance Number (SIN):</b> _____	
<p>Your SIN is being collected to allow us to uniquely identify you within our system and to provide you with information if you may require assistance or have questions about your application. This information also assists us in improving our Internet suite of products and services.</p> <p>We take all reasonable precautions to keep your personal information secure. Access to your personal information is restricted to prevent unauthorized access, modification or misuse, and is only permitted among employees responsible for the delivery of the program.</p>	

### Mailing Address

<b>Street / Rural Address:</b>	<b>Apartment / Suite / Unit:</b>
<b>City / Town / RM:</b>	<b>Postal Code:</b>
<b>Phone number:</b>	<b>Email:</b>

### Child's Information

1.

<b>First Name:</b>	<b>Middle Name:</b>	
<b>Last Name:</b>	<b>Health Card Number:</b>	
<b>Date of Birth (YYYY/MM/DD):</b>	<b>Sex:</b> <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Prefer not to disclose	
<b>Parent/Guardian Relationship to Child:</b>	<input type="checkbox"/> Parent	<input type="checkbox"/> Legal Guardian
	<input type="checkbox"/> Person of Sufficient Interest	<input type="checkbox"/> Other: _____

(Enter information below if applying for more than one child)

2.

<b>First Name:</b>	<b>Middle Name:</b>	
<b>Last Name:</b>	<b>Health Card Number:</b>	
<b>Date of Birth (YYYY/MM/DD):</b>	<b>Sex:</b> <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Prefer not to disclose	
<b>Parent/Guardian Relationship to Child:</b>	<input type="checkbox"/> Parent	<input type="checkbox"/> Legal Guardian
	<input type="checkbox"/> Person of Sufficient Interest	<input type="checkbox"/> Other: _____

3.

<b>First Name:</b>	<b>Middle Name:</b>	
<b>Last Name:</b>	<b>Health Card Number:</b>	
<b>Date of Birth (YYYY/MM/DD):</b>	<b>Sex:</b> <input type="checkbox"/> Male <input type="checkbox"/> Female <input type="checkbox"/> Prefer not to disclose	
<b>Parent/Guardian Relationship to Child:</b>	<input type="checkbox"/> Parent	<input type="checkbox"/> Legal Guardian
	<input type="checkbox"/> Person of Sufficient Interest	<input type="checkbox"/> Other: _____

### Preferred Option for Receiving Benefit

We encourage you to select the direct deposit option. Direct deposit is convenient, reliable, secure and allows us to process your application more efficiently.

<b>Payment Option:</b>	<input type="checkbox"/> Direct Deposit	<input type="checkbox"/> Cheque
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## Consent for Collection Use and Disclosure of Information and Declaration

I/Parent or Guardian \_\_\_\_\_ (parent/guardian name) of  
\_\_\_\_\_ (child's name), of \_\_\_\_\_ (city of residence)

**understand and/or confirm:**

- That to apply for the Autism Spectrum Disorder Individualized Funding, I am providing information that is considered personal information pursuant to The Freedom of Information and Protection of Privacy Act (FOIPPA) and personal health information pursuant to The Health Information Protection Act (HIPA). Both types of information will be referred to as Information throughout the rest of the document.
- That I have reviewed this application package to determine that my child is eligible to receive Autism Spectrum Disorder Individualized Funding.
- I certify that the information provided in this application is accurate and true to the best of my knowledge.

**Further, I provide consent (agree):**

- To the release of the Application package and Information to the Ministries of Health and Education; who may provide information back to the Ministry of Social Services. I understand that when information is shared, it will be limited to what is needed or as allowed by law.
- My application is being submitted to the Ministry of Social Services where they will open a file and be responsible for keeping my information secure and confidential.
- My application and the Information I provide within will be used by the Ministry of Social Services for the purposes of establishing eligibility to receive Autism Spectrum Disorder Individualized Funding.
- My information may also be used for evaluation and analysis. The Information used will be limited to what is needed ensuring my Information is kept confidential and secure at all times. Data included in reports will be de-identified (it will not include our names or other identifying information). It may include gender or sex and ages. This analysis may be shared with participating ministries.
- I can withdraw my consent at any time by writing or talking to the Autism Spectrum Disorder Individualized Funding Supervisor. If withdrawing consent, it will mean my application cannot continue and I cannot receive funding from Autism Spectrum Disorder Individualized Funding. Any information collected prior to withdrawal will continue to be used for analysis purposes.
- I have a right to request a copy of my file free of charge through the access request process. I will receive a copy of the file with all information I am legally entitled to receive.
- I understand that the information provided in this application package will be retained and disposed of in accordance with The Archives and Public Records Management Act.

**I agree that if my child/children is/are eligible for the Autism Spectrum Disorder Individualized Funding:**

- I will use the benefit for its intended purpose in the purchase of eligible services that will support my child with ASD;
- I understand that I may be selected for a benefit review during which I will be asked to provide confirmation of services purchased (including receipts) with the ASD IF benefit;
- I understand that the Ministry of Social Services may request repayment of benefits spent on ineligible expenses and agree to repay them upon request.

**I confirm that my child meets all four of the eligibility requirements set out at the beginning of this application.**

\_\_\_\_\_  
**Signature of Parent/Legal Guardian**

\_\_\_\_\_  
**Date (YYYY/MM/DD)**