

The personal information collected on this form will be used for the purposes of determining eligibility for Autism Individualized Funding through the Ministry of Social Services and will be treated confidentially in compliance with the *Health Information Protection Act* and 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 Ministry of Social Services, 1-833-304-1774.

This form is to be completed for:  
Saskatchewan residents who have a child under the age of 6 and has received a diagnosis of Autism Spectrum Disorder (ASD) in order to access Autism Individualized Funding.

**COMPLETED PAGE 1 OF FORM TO BE RETURNED TO MINISTRY OF SOCIAL SERVICES**

**PART ONE – TO BE FILLED OUT ELECTRONICALLY BY A QUALIFIED SPECIALIST**

CHILD'S NAME	DATE OF BIRTH (yyyy/mm/dd)	HEALTH CARD NUMBER
PARENT/GUARDIAN'S NAME	HOME TELEPHONE NUMBER	WORK TELEPHONE NUMBER
ADDRESS	CITY/TOWN	POSTAL CODE

**PART TWO – TO BE FILLED OUT ELECTRONICALLY BY A QUALIFIED SPECIALIST (only signature should be hand written)**

**SECTION 1 – QUALIFIED SPECIALIST INFORMATION**

NAME OF SPECIALIST COMPLETING FORM		PLEASE CHECK DISCIPLINE	
		<input type="checkbox"/> Paediatrician	<input type="checkbox"/> Psychiatrist
		<input type="checkbox"/> Registered Psychologist	
WORK ADDRESS	CITY/TOWN	PROVINCE/TERRITORY	POSTAL CODE
TELEPHONE NUMBER	FAX NUMBER	EMAIL ADDRESS	COLLEGE ID/REGISTRATION NUMBER

**SECTION 2 – CONFIRMATION OF DIAGNOSTIC INFORMATION**

PLEASE CHECK BOX IF THE CHILD HAS ASD ACCORDING TO CRITERIA OF DSM-5/ICD-10 <input type="checkbox"/>	DATE OF DIAGNOSIS (yyyy/mm/dd)	LOCATION (CITY/PROVINCE/TERRITORY)
REVIEW OF PREVIOUS DIAGNOSIS <input type="checkbox"/> (Clinician has reviewed existing documentation and is comfortable with the assessment process used. If not, child is referred for full diagnostic assessment.)	NAME OF PERSON WHO REVIEWED THE INFORMATION	DATE OF REVIEW (yyyy/mm/dd)

\_\_\_\_\_  
NAME AND SIGNATURE OF QUALIFIED SPECIALIST COMPLETING FORM AND PROVIDING FINAL DIAGNOSIS  
(must have done clinical assessment of child or clinical review of previous assessment)

\_\_\_\_\_  
DATE SIGNED (yyyy/mm/dd)

**PART THREE – TO BE FILLED OUT BY PARENT OR GUARDIAN**

I consent to release this information to the Ministry of Social Services for the purpose of determining eligibility for Autism Individualized Funding. This information will be treated confidentially and in compliance with the *Health Information Protection Act* and the *Freedom of Information and Protection of Privacy Act*.

\_\_\_\_\_  
SIGNATURE OF PARENT OR GUARDIAN COMPLETING FORM

\_\_\_\_\_  
DATE SIGNED (yyyy/mm/dd)

**PLEASE UPLOAD YOUR COMPLETED DIAGNOSTIC FORM TO YOUR APPLICATION FOR INDIVIDUALIZED FUNDING**

**AVAILABLE AT [autismfunding.saskatchewan.ca](http://autismfunding.saskatchewan.ca)**

**If you are mailing in your application for individualized funding please include this form.**