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 ◯ Paediatrician ◯ Psychiatrist ◯ 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 ☐	DATE OF DIAGNOSIS (yyyy/mm/dd)	LOCATION (CITY/PROVINCE/TERRITORY)
REVIEW OF PREVIOUS DIAGNOSIS ☐ (Clinician has reviewed existing documentation and is comfortable with diagnosis of ASD. 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)

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