



Education and Early  
Childhood Development

## APPLICATION FOR PRESCHOOL AUTISM FUNDING

*The following information should be completed by the parent or guardian requesting Preschool Autism Funding for a child with a diagnosis of Autism Spectrum Disorder. Please see Autism Funding Guidelines for eligibility criteria.*

Date: \_\_\_\_\_

### PART A: CHILD INFORMATION

Name of Child:	Date of Birth (YYYY/MM/DD)
Diagnosis:	<input type="checkbox"/> Autism <input type="checkbox"/> Autism Spectrum Disorder <input type="checkbox"/> Asperger Syndrome <input type="checkbox"/> PDD-NOS
Diagnosing Professional:	
Documentation of diagnosis with required assessments provided:	<input type="checkbox"/> Yes <input type="checkbox"/> No
Current Learning Setting:	<input type="checkbox"/> Early Childhood Centre <input type="checkbox"/> Home <input type="checkbox"/> Other _____

### PART B: FAMILY INFORMATION

Parent or Guardian's Name:	
Address (City/Town/Postal Code):	
Daytime phone # (    ) Evening phone # (    )	Email:

### PART C: EMPLOYER INFORMATION

For purposes of Preschool Autism Funding, the parent or guardian is the employer of the Autism Assistant. If requested by the parent, a licensed early childhood centre may be the employer. In all cases, the funding is paid to the designated employer with required documentation of completed service. (See Autism Funding Guidelines for required documentation).

<b>Employer</b>	<input type="checkbox"/> Parent/Guardian <input type="checkbox"/> Early Childhood Centre
Parent:	
Early Childhood Centre Name: (if applicable)	
Centre Director/Administrator: (if applicable)	
Address (City/Town/Postal Code):	
Phone # (    )	Email
Direct Deposit Option:	<input type="checkbox"/> Yes, I would like direct deposit to the employer (see Direct Deposit form-Appendix I) <input type="checkbox"/> No, please send funds via a check

**PART D: EMPLOYEE INFORMATION**

Name:	
Address (City/Town/Postal Code):	
Phone # (    )	Email:
<input type="checkbox"/> Not an immediate family member (parent, sibling or person living in the home with the child) <input type="checkbox"/> At least 18 years of age	
<input type="checkbox"/> Vulnerable Persons Check completed (recommended) <input type="checkbox"/> Criminal Record Check completed (recommended)	

*(Additional employee information forms are available at the end of the application form, if required)*

**PART E: EARLY YEARS AUTISM SERVICE INFORMATION**

<b>INTENSIVE BEHAVIOURAL INTERVENTION</b>	
Recommended Number of IBI Hours <input type="checkbox"/> 10 hours <input type="checkbox"/> 20 hours <input type="checkbox"/> 25 hours <input type="checkbox"/> Other _____	Start Date: (YYYY/MM/DD) _____  End Date: (YYYY/MM/DD) _____ (if known)  Early Years Autism Specialist/Coordinator Signature  _____

Funded Amount is based on Time Tracking Logs submitted and actual hours of service provided	\$ _____ per hour up to recommended number of hours.  [maximum \$13.18 per hour, includes 12.59% for mandatory employer related costs of Canada Pension, Employment Insurance, Worker's Compensation and Vacation Pay]
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The Parent or Guardian is required to review the following statements and indicate agreement by providing signature below.

1. I am the parent having primary responsibility for my child or legal guardianship of this child
2. I certify that the information provided above is correct.
3. I understand that the information on this form will be used to determine eligibility and continuing eligibility for Autism Funding provided by the Department of Education and Early Childhood Development.

Name of Parent /Guardian (PLEASE PRINT)	Signature of Parent /Guardian	Date Signed (YYYY/MM/DD)
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Please retain a copy of the application for your records. Mail, fax, email or bring the original application to

**Attention: Autism Funding Administrator**  
 Department of Education & Early Childhood Development  
 Holman Centre, 250 Water Street, Suite 101  
 Summerside, PE C1N 1B6  
 Telephone: (902) 438-4854  
 Toll-free: 1-888-482-5330  
 Fax: (902) 438-4874  
 Email: autismfunding@gov.pe.ca

Personal information on this form is collected under section 31 of the *Freedom of information and Protection of Privacy Act* R.S.P.E.I. 1988, c.F-15.01, as it relates directly to and is necessary for access to Autism Funding and Services. If you have any questions about this collection of personal information, you may contact the Autism Coordinator at (902)569-7792.

**For internal use:**

Autism Funding Approved - Yes <input type="checkbox"/> No <input type="checkbox"/>	Date approved: _____
Early Years Autism Coordinator Signature: _____	