BRITISH COLUMBIA | Ministry of Children and Family Development

AUTISM PROGRAMS
REQUEST TO PAY
SERVICE PROVIDERS/SUPPLIERS

The personal information collected on this form will be used for the purpose of providing funds though 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

LAST NAME	FIRST	MIDDLE	HOME PHONE NUMBER	WORK PHONE NUMBER
			( )	( )
ADDRESS			CITY/TOWN	POSTAL CODE

SECTION 2 CHILD INFORMATION

LAST NAME	FIRST	MIDDLE	DATE OF BIRTH (YYYY/MM/DD)	Is this a child in the care of the ministry?
				☐ Yes ☐ No

PART A SERVICES

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

SERVICE PROVIDER NAME			PAYMENT TO BE PROVIDED TO (Check one):
			☐ SERVICE PROVIDER
AGENCY NAME (If Applicable)			☐ AGENCY
ADDRESS	CITY/TOWN	POSTAL CODE	PHONE NUMBER
			( )

TYPE OF SERVICE(S)	START: YYYY/MM/DD	END: YYYY/MM/DD
	FEE (include PST) 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.

SUPPLIER NAME	CONTACT PERSON	PHONE NUMBER
		( )
ADDRESS	CITY/TOWN	POSTAL CODE

PLEASE PROVIDE DETAILED DESCRIPTION	ITEM COST

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.

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

Autism funding must be used for eligible autism intervention expenses, as outlined in A Parent's Handbook: Your Guide to Autism Programs.

SECTION 1 AND SECTION 2

Complete all information about you and your child

- The parent/guardian must be the person who signed the Autism Funding Agreement.

PART A

Complete this section of the form to request authorization for autism intervention services.

- Fill in the service provider's name, address and phone number
    - Payment will be sent to the address listed
    - Indicate to whom the cheque will be payable. You have the choice of "Service Provider" or "Agency"
- Fill in the "Type of Service" (e.g. Behaviour Consultant, Occupational Therapy)
- Fill in the "Start" and "End" dates
    - The "End" date must be on or before the last day of the month of your child's birthday
      It is recommended that RTP forms be completed for at least three months to reduce your paperwork
- Enter the Hourly or daily rate of the service and the total amount that will be spent. The Total Amount can be calculated in the following way:
    - Hourly rate (e.g. $75)
    - multiplied by the expected number of hours of service per month (e.g. 2 hours)
    - multiplied by the number of months that service will be provided (e.g. 12 months)
    - equals the Total Amount (e.g. $1,800)

Paying multiple professionals from a single agency

If an agency will be paid for a package of services, list all services and the hourly rate of each service in the Type Of Services box. The Total Amount can be calculated by using the method described above for each service and then adding the totals for each service together.

PART B

Complete this section of the form to authorize payment to a service provider/supplier for travel, training, equipment or supplies. The following information is required for each type of expense:

Travel – Name of traveller, reason for travel, type of expense (e.g. hotel, mileage), travel from/to location, dates of travel and cost

Training – Name of person who will receive training, name/type of training, dates of training and cost

Equipment and Supplies – Item(s) purchased, cost

ADDITIONAL INFO

Parents are responsible for deciding if they will allocate a portion or all of their funds to one service provider/agency.

To change of cancel this RTP, parents complete and submit a Request to Amend Invoice Payment Authorization form to the Autism Funding Unit

Up to 20% of autism funding may be spent on eligible, travel, training, equipment and supplies related to intervention annually.

If a service provider wishes to be paid by direct deposit into his or her account, the Autism Funding Unit can provide him or her with a direct deposit form.

The service provider must mail, email or fax the invoice to the Autism Funding Unit to receive payment.

The Provincial Government is GST exempt for services/purchases that occurred prior to July 1, 2010. Service providers should not include GST in their billings.

Contact the Autism Funding Unit for assistance with completing this form

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

Email: mcf.autismfundingunit@gov.bc.ca