Care Provider Form

Supporting Documentation for Application to the IWK Autism Family Support Fund

Examples of Care Providers who may complete this form to support the family application include: occupational therapist, psychologist, social worker, speech-language pathologist, developmental interventionist, EIBI staff, teacher, or physician.

To: Autism Family Support Fund
Application Review Committee

Client's Name: DOB:

I understand the above-noted child/youth may be eligible for assistance from the IWK Autism Family Support Fund. I am writing to confirm the following (check only those that apply):

☐ I confirm that the child has a diagnosis of autism.

☐ I understand that the family is making an application for funds in Option 1 and/or Option 2 of the application. I have reviewed the items listed in the application form and support the request for funding or for reimbursement for the items listed.

Care Provider Information:

Name:
Professional Designation:
Phone:
Email:

☐ I agree to be contacted by IWK staff if there are any follow-up questions about the contents of this form.

This completed form must accompany the application.