



The personal information collected on this form will be used for the purpose of providing funds through Autism Funding: Under Age 6 Program and Autism Funding: 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 Support Needs Policy Branch, (250) 952-6044, PO Box 9719 Stn Prov Govt, Victoria, BC V8W 1C3.

THIS AGREEMENT

made on the ____ day of _____, _____.

BETWEEN:

PROVINCE OF BRITISH COLUMBIA, represented by the Minister of Children and Family Development (the "Province")

AND:

(THE "CARE PROVIDER") FIRST/ MIDDLE/ SURNAME

RE:

born on (THE "CHILD") (YYYY/MM/DD)

In consideration of being enrolled in autism invoice payment the Care Provider agrees to the following:

1. Definitions

In this Agreement:

- a) "Autism Intervention Expenses" means expenses defined as eligible expenses in A Parent's Handbook: Your Guide to Autism Programs;
b) "Child" means a person ages 0 through 18, with a diagnosis of Autism Spectrum Disorder who meets the eligibility criteria as outlined in A Parent's Handbook: Your Guide to Autism Programs;
c) "Funds" means the amount provided under invoice payment;
d) "Care Provider" means the Child's Care Provider under an Extended Family Program (EFP) Agreement, or a Child in the Home of a Relative (CIHR) Program Agreement, having primary care and control of the Child;
e) "Behavioural Plan of Intervention" means a plan developed by a Behaviour Consultant that identifies the Child's intervention program and that includes a school transition component for the Child if over 4.5 years of age;
f) "Province" includes the Minister or Deputy Minister of the Ministry of Children and Family Development and any person authorized to act on his/her behalf respecting this Agreement; and
g) "Service Providers, Behaviour Consultants and Behaviour Interventionists" means those persons having the respective required qualifications as outlined in A Parent's Handbook: Your Guide to Autism Programs.

2. Province's Obligations

The Province will pay on behalf of the Care Provider for the benefit of the Child the amount the child is eligible to receive in accordance with A Parents' Handbook: Your Guide to Autism Programs.

3. Care Provider's Obligations

The Care Provider shall:

- a) use the Funds for Autism Intervention Expenses for the child and for no other purpose.
b) if the Child is under age 6, submit to the province within 120 days of the date of this Agreement, a copy of the Behavioural Plan of Intervention for the Child and any subsequent revisions.
c) notify the Province in writing within 30 days when:
i) the Care Provider's address changes;
ii) the Child is for any reason no longer in the Care Provider's care or custody;
iii) there is any change in circumstance which may eliminate or reduce the need for assistance.
d) be solely responsible for the amounts to be invoiced by and paid to Service Providers that are:
i) in excess of the maximum annual funding;
ii) deemed ineligible by the province; or,
iii) received by the province more than 6 months after the date of service and/or date of equipment purchase.
e) be solely responsible for arranging for, assessing and selecting Service Providers, Behaviour Consultants and Behaviour Interventionists, that are at least 19 years of age and possess a clear and current criminal record check that is updated at least every 5 years.
f) except as provided for paragraphs 2 and 6, not in any way commit or purport to commit the Province to the payment of any money.
g) indemnify and save harmless the Province, its employees and agents (each an Indemnified Party), from any and all losses, claims, damages, actions, causes of actions, costs and expenses that an Indemnified Party may sustain, incur, suffer or be put to at any time either before or after this Agreement ends, which are based upon, arise out of or occur, directly or indirectly, by reason of any act or omission of the Care Provider or any agent, employee or contractor of the Care Provider pursuant to this Agreement, accepting always liability arising out of the independent negligent acts of the Indemnified Party.
h) with regard to any obligations of the Care Provider as an employer under the Employment Standards Act, Workers' Compensation Act, Human Right's Code, Employment Insurance Act, Income Tax Act or Canada Pension Plan Act, or similar laws to which the Care Provider may be subject:
i) be solely responsible for determining the Care Provider's obligations under those laws, and the Care Provider expressly acknowledges that the Province has made no representations with respect to any such obligations, and
ii) as applicable, comply with and pay all taxes, fees and assessments calculated to be due by the Care Provider under those laws.
j) Not assign this Agreement.

4. Term of Agreement

The term of this Agreement commences on the 1st day of

_____, _____
(MONTH) (YEAR)

5. Termination

- a) This Agreement automatically ends:
 - i) at the end of the month of the Child's 6th birthday; if eligible for Autism Funding: Under Age 6 Program OR at the end of the month of the Child's 19th birth date if eligible for Autism Funding: Ages 6–18 Program;
 - ii) when the Child is no longer eligible to receive the Funds as determined in accordance with *A Parent's Handbook: Your Guide to Autism Programs*;
 - iii) at such a time as the Child no longer resides in British Columbia; or
 - iv) at such a time as the EFP or CIHR Agreement ends, or the Child is, for any reason, no longer in the Care Provider's care or custody; whichever first occurs.
- b) If the Care Provider fails to comply with any of his or her obligations under this Agreement, the Province may immediately terminate this Agreement by providing written notice to the Care Provider and may pursue any other remedies the Province considers necessary or appropriate.
- c) The Province or Care Provider may terminate this Agreement for any reason on 30 days written notice to the other party.
- d) If this Agreement is terminated pursuant to subparagraphs (a), (b) or (c):
 - i) the Province will be under no further obligation to the Care Provider except to pay the Care Provider an amount which is the amount of Funds that the Care Provider or service provider is entitled to receive to the date the Agreement is terminated less the amount of any unexpended Funds determined in accordance with subparagraph 3(d); and
 - ii) Subparagraphs 3(a), (g), and (h) will, despite the expiration or termination of this Agreement, remain and continue in full force and effect.

6. General

- a) The Province's obligation to pay money under this Agreement is subject to the *Financial Administration Act*, which makes that obligation subject to an appropriation being available in the fiscal year of the Province during which payment becomes due.
- b) The Province may take any steps it deems necessary to confirm that the Funds paid under this Agreement are used for Autism Intervention Expenses.
- c) A person selected by the Care Provider and paid with the Funds shall not be a person who is the Care Provider of the Child or a person who lives in the same household as the Child.
- d) The Care Provider acknowledges that:
 - i) he/she has read the terms and conditions of this Agreement and is satisfied he/she understands it; and
 - ii) he/she has read *A Parent's Handbook: Your Guide to Autism Programs* and understands it.

7. Total Assistance Payable

Notwithstanding any other provision of this Agreement, in no event shall the amount payable on behalf of the Care Provider for the benefit of the Child exceed, in any year, the amount established by the Province from time to time as the amount payable:

- a) if the family is eligible for Autism Funding pursuant to the Autism Funding: Under Age Six Program; and
- b) if the family is eligible for Autism Funding pursuant to the Autism Funding: Ages 6–18 Program.

Signed on behalf of the Province by an authorized representative of the MCFD Autism Funding Unit on the

_____ day of _____, _____.

MCFD AUTISM FUNDING UNIT REPRESENTATIVE
SIGNATURE
TITLE

Signed by the Care Provider on the

_____ day of _____, _____.

CARE PROVIDER'S NAME (First/Middle/Surname)		
ADDRESS		
CITY/TOWN	POSTAL CODE	DAYTIME PHONE ()
CARE PROVIDER'S SIGNATURE		

This form was prepared by/with the assistance of:
(Please print clearly)

MCFD REPRESENTATIVE	DATE (YYYY/MM/DD)
---------------------	-------------------