

Wellington Summer Funding Application

Child's Legal Name: _____ Birthdate: _____ Gender: _____

Diagnosis: _____

_____ I have enclosed proof of diagnosis (clear, legible copy)

Parent/Guardian Name: _____

Address: _____ City/Town: _____

PC: _____ Telephone: _____ Email: _____

Application Process

- ◆ Please complete your signed application and submit with copy of diagnosis.
- ◆ Autism Ontario Wellington Chapter will notify all applying families about the amount of approved funds by June 15, 2019. You will receive further instructions to submit eligible receipts no later than September 30, 2019 before reimbursement is made. Once all required documentation has been received reimbursement will occur within 30 business days.
- ◆ Autism Ontario Wellington Chapter will provide a \$400.00 reimbursement for each child/youth for camp registration fees incurred by their parent/guardian who retains services of a one-to-one support worker (worker must be 18 or older) AND/OR camp fees incurred to attend a summer program/camp between July 1 and August 31 for their child/youth with ASD (up to age of 21).
- ◆ Membership in Autism Ontario Wellington Chapter is required to access the Fund. To become a member please visit: www.autismontario.com/membership-opportunities

Release of Liability

I understand that no information will be released without my authorization. I will indemnify and save harmless Autism Society Ontario (operating as Autism Ontario) and each of their officers, directors, employees, volunteers and agents from and against any and all claims, actions or demands, including, without limitation, reasonable legal and accounting fees, alleging or resulting from my use of the family funding. I am aware that Autism Ontario neither supports nor endorses any one camp or program. I am also aware that Autism Ontario does not endorse or train any individual for the purpose of working one on one with my child. (Autism Ontario complies with the *Personal Health Information Protection and Electronic Document Act*. All information gathered is stored in a confidential manner. To view Autism Ontario's Privacy Policy, please visit www.autismontario.com.)

By signing I am acknowledging the release of liability above and I am certifying that the information provided in this application is

_____ I am a member of Autism Ontario.

_____ I would like to receive information about volunteer opportunities in my area.

Parent/Guardian Signature: _____ Date: _____

Please email Summer Program Application and Proof of Diagnosis to centralwest@autismontario.com or mail both documents to:

Autism Ontario - Wellington
1179 King Street West, Toronto ON M6K 3C5