IRM REQUEST REGISTRATION FORM

IRM
Independent Review Mechanism
for the Autism Intervention Program

Contact Niagara

Please complete SECTION 1 of this form and return by fax, email, or in-person to your Regional AIP Provider/Funding Administrator.

SECTION 1 – To be completed by Parent/Caregiver:

AIP PROVIDER:

- ☐ Kinark Child and Family Services
- ☐ ErinoakKids
- ☐ Children's Hospital of Eastern Ontario
- ☐ Hamilton Health Sciences
- ☐ HANDS the Family Help Network
- ☐ Pathways for Children and Youth
- ☐ Thames Valley Children's Centre
- ☐ Child & Community Resources
- ☐ Surrey Place Centre

DATE FORM SUBMITTED: _____ (Year/Month/Day)

Date you received written notification of the AIP Provider's decision: _____ (Year/Month/Day)

NAME OF CHILD: (Please Print Clearly)

_____ ☐ **MALE** ☐ **FEMALE**
Last First

CHILD'S DATE OF BIRTH: _____ (Year/Month/Day)

Child Resides with Caregiver(s) Below: ☐ Yes ☐ No

PARENT(S)/CAREGIVER(S): _____
Last First

RELATIONSHIP: _____ **TITLE:** ☐ **Dr.** ☐ **Mr.** ☐ **Mrs.** ☐ **Ms.** ☐ **Miss**

PARENT/CAREGIVER ADDRESS: _____
Street City Prov Postal Code

TELEPHONE: ( ) _____ **OR** ( ) _____

If Child does not reside with the Caregiver(s) named above, please explain:

CONSENT & AGREEMENT:

I, the undersigned agree to the exchange of information between the Autism Intervention Program (AIP) Provider indicated above and Contact Niagara, the coordinator of the Independent Review Mechanism, for the purpose of completing the review that I have requested, of the decision pertaining to my child's ineligibility for or discharge from IBI. I understand the first step in the review process is an internal review by the AIP Provider.

_____ _____
Signature Year/Month/Day

SECTION 2 – To be completed by AIP Regional Provider:

DECISION BEING REVIEWED: ☐ ELIGIBILITY ☐ DISCHARGE

SERVICE TYPE: ☐ DFO ☐ DSO

Date Written Notification of Decision Sent to Family: _____ (Year/Month/Day)

Date IRM Notified of Request (Date of Data Entry to Webtracker): _____ (Year/Month/Day)