Choices In Autism Treatment ('CIAT')

Implementing parental choice in autism health care

Respectfully submitted to Deputy Minister Chris Haynes
Ministry of Child and Family Development

August 2001

Families for Early Autism Treatment of British Columbia

Contents:

Summary and recommendations

The Ministry for Child and Family development ('MCFD' or the 'Ministry') is *highly* unsuited for the delivery of effective autism treatment. The delivery of medically necessary treatment is not the mandate nor the expertise of the Ministry, as noted in the landmark BC Supreme Court ruling on autism treatment (Auton 2000). There are several structural, philosophical, and expertise reasons why MCFD consistently flounders in the area of medically required mental health intervention. In view of this, it is strongly recommended the Ministry formally approach Cabinet for an order to transfer responsibility for autism treatment to the Ministry of Health Services (MOHS). There is a strong consensus amongst mental health professionals with respect to such a change in the 'line of command'.

In the interim, immediate action is required to close the autism treatment gap and bring BC into compliance with the Charter of Rights and Freedoms. It is now over a year since BC Supreme Court ruled government autism policy constitutes 'direct discrimination' against children with autism; the discrimination continues — there is no public funding in place for effective autism treatment. The EIBI program is woefully inadequate to the challenge. Constitutional law must be respected by the government of British Columbia. Moreover, government must fulfill the Liberal 'New Era' promise stating that with respect to early intervention programs for children with autism, "the province must meet its legal duties under the Canada Health Act" (please see Appendix A of this brief).

A 'parent choice' program of individualized funding based on an *existing* MOHS model developed in 1997 (the CSIL program) is ideally suited for rapid implementation of choice in autism treatment, as well as bringing government into compliance with the Charter and government’s “... legal duties under the Canada Health Act”. Importantly, adoption of the CSIL model of service delivery fully meets Ministry needs for accountability and the beneficial use of funds.

Introduction

This brief, *'Choices In Autism Treatment'*, has been authored for the Deputy Minster of Child and Family Development, Mr. Chris Haynes, in response to his written invitation to FEAT of BC (07/27/2001) for additional input regarding a mutually desired pursuit for 'common ground' in the long-standing autism dispute between BC families and the Government of British Columbia. The purpose of this brief is to address concerns Ministry staff may have regarding specific aspects of implementing 'parent choice' in publicly funded autism treatment — choice that will balance current MCFD autism policy of government-appointed regional monopolies, contracted under the inadequate EIBI pilot program.

The EIBI policy is born of a 'top-down' paradigm holding that government can run things better than everyone else. The current provincial government is known not to share this philosophy. MCFD's determined implementation of the previous government's autism policies (the EIBI program) not only runs diametrically opposite to the overwhelming mandate for change delivered in the provincial 2001 election, it also affirms a sad reality for disabled children: whether government is 'on the left' or 'on the right' makes little difference. The lack of effective public funding for autism treatment confirms that discrimination against children afflicted with autism is *systemic*; it is deeply rooted in the bureaucracy — an 'auto-pilot' discrimination against the disabled from which there seems to be no cure, escape, or protection. The Charter of Rights and Freedoms, in theory, exists for precisely this protection. The Charter is all that can balance an unequal contest between government and our demographic minority of vulnerable, disabled children who continue to be shut out of the 'Canadian Social Contract' drafted by and for the benefit of the demographic majority.

The contents of this brief are based on insight gained over many years of controversy between families and the Ministry. It is also based on a *thorough* understanding of consistently flawed government autism policy. This report is submitted to the Deputy Minister in good faith and in the sincere hope that meaningful policy reform will be ***quickly*** implemented in the best interest of our severely ill group of children.

It must be firmly reiterated at the outset of this brief that although we are committed to working with MCFD in the short term — in the best interest of children with autism — we remain firmly committed to the ultimate and rightful transfer of responsibility over autism treatment to the Ministry of Health Services. This position is consistent with the recommendations of the BC Supreme Court, for what the Court declared is 'medically necessary' autism treatment. The view that mental health services should be transferred to MOHS is widely held by BC physicians and psychologists. Nevertheless, in the short term we look forward to working with MCFD to offer our perspective on an autism treatment policy that can take effect quickly to provide publicly funded, ***universally accessible*** and ***effective*** treatment for this neurologically ill group of children. Moreover, it is important to stress that despite MCFD'S efforts since the landmark July 2000 BC Supreme Court ruling on autism treatment, every day that passes is a day government continues to violate the constitutional rights of children suffering with autism.

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A) 'Equitable Allocation of Funds'

Funding autism treatment is not a 'zero sum' game

Over several years in FEAT BC's difficult, ongoing autism dispute with government, there has been a recurring theme regarding why the Ministry opposes effective, universally accessible treatment for children afflicted with autism. Simply stated, Ministry staff have argued that providing children with autism treatment they require to overcome their disability (now affirmed and mandated by BC Supreme Court) will take scarce resources away from 'other children' with disabilities. MCFD staff have argued in the past that government resources are limited and, therefore, treatment needs of autistic children must be 'balanced' with the rights of other disabled children who are under mandate of the Ministry. This *systemic* flaw in Ministry thinking is euphemistically referred to by staff as a concern with the 'equity' of policies for autism treatment. Unfortunately, the analysis of 'equity' or 'fairness to others' is only applied to other *disabled* children as opposed to all NON-disabled children who receive publicly funded health care. This highly discriminatory mind-set is a key example of a structural flaw in MCFD that makes its special needs policy staff highly unsuited for a genuinely 'equitable' delivery of medically required treatment.

Although at first, MCFD special needs staff's 'zero-sum' argument appears compelling, BC Supreme Court has ruled it inappropriate and discriminatory. BC Supreme Court ruled that Ministry policy AND its resource argument, *"pits groups of disadvantaged people against each other ..."*

In the Auton 2000 decision, BC Supreme Court states:

> [128] *"The Crown seeks to justify its discretion in allocating expenditure among children with special needs by comparing autistic children with other groups of disabled children or comparing differing degrees of disability. That approach, which* ***pits groups of disadvantaged people against each other to determine who is more disadvantaged, was expressly disavowed*** *in Granovsky, at para. 67."* emphasis added.
>
> [129] *"In this case,* ***the appropriate comparative groups are non-autistic children or mentally disabled adults.*** *In comparison to both non-autistic*

> *children and mentally disabled adults, the infant petitioners are subject to differential treatment based on the enumerated ground of mental disability. Indeed, as children and mentally disabled, they are doubly vulnerable.*" [Auton et al. v. AGBC, 2000 BCSC 1142, emphasis added].

To summarize, the oft referenced staff argument relating to 'equitable allocation of funds' has been expressly and unambiguously disavowed by the court and should be excised from the debate (internal and external) on the nature of new autism policy required to bring BC into legal compliance. BC Supreme Court has spoken to the issue; the limited 'resource' argument does not justify discrimination against children with autism. Moreover, BC Supreme Court's decision affirms that provision of genuine, effective, science-based and '*medically necessary*' autism treatment, <u>is not to be weighed against MCFD expenditures for other "groups of disadvantaged people</u>".

As stated previously, autism treatment is a recognized 'health' issue and NOT a social services issue — the court reaffirmed this and recommended Autism treatment should be the responsibility of health. Even if such a transfer is not immediately made, MOHS should nonetheless be expected to share in the cost of implementing autism treatment on a universal basis. In short, the 'equity' of budget allocation argument also fails because it is government ***as a whole*** that must comply with the court's ruling to end 'direct' autism treatment discrimination — not MCFD alone.

B) 'Beneficial Allocation of Individualized Funds'

The long-standing MCF (now MCFD) argument

A long-standing MCFD position has been that it is better to expend Social Services resources on 'trusted' government appointed contractees rather than directly provide families with individualized funding for the private purchase of autism treatment services that otherwise DO NOT EXIST in MCFD, Medicare or MOHS. The implicit argument is that families really 'can't be trusted with the money'. The rationale for this staff position is unfortunately rooted in the organizational culture — the problem is *structural* insofar as the Ministry staff culture is founded on a poverty-based, social services model. BC Supreme court affirms this in the Auton 2000 ruling:

> [55] *"... **MCF operates on a social services model** that has neither the mandate nor the expertise to deliver treatment. The Crown describes MCF's primary program areas as child protection and guardianship, child family and community services, adult services and regional support. Many of the programs available under the MCF are subject to income testing."* [Auton et al. v. AGBC, 2000 BCSC 1142, emphasis added].

"Parents aren't responsible enough": the MCFD poverty-based bias

Flowing directly from staff's poverty-based bias is the deeply rooted organizational view that "parents of children with autism aren't responsible to handle individualized funding" to run necessary treatment programs. This government view is patronizing and paternalistic in the extreme. It is fundamentally based on the social services bias that recipients of government funds are somehow deficient, at the 'low end' of the socio-economic spectrum — in other words the poorly educated, social services recipients typically faced by MCFD social workers. It cannot be stated emphatically enough that parents of children with autism DO NOT FIT THE MODEL OF SOCIAL SERVICES DISTRESS. A neurologically ill child does not have anything to do with the typical child protection or poverty-based scenario. It is self evident that a social services ministry is ill suited to deliver a 'medically necessary' treatment for autism — BC Supreme Court has said as much. The practical 'down side' to this shortcoming is that Ministry staff continue to hold the view — and base policy on — the implicit assumption that parents of children stricken with autism are like 'all the rest' of the social services recipients ... not responsible enough to be trusted with the money.

This is obviously a woeful misconception of families struggling to save their children from the ravages of autism. The reality is that outside the social services myopia, there is a Ministry of Health reality of 'individualized funding' that is already in place — a program designed to fund palliative care on an in-home basis in a *far* more cost effective, efficient manner than government-contracted facilities can provide. The MOHS program is the blue print for how MCFD can quickly deliver 'parent choice' in autism treatment, while readily addressing staff concerns regarding financial accountability (a.k.a. 'beneficial allocation of funds' or 'responsible' use of funds).

C) How to Implement a '*Choices in Autism Treatment*' program

"No need to reinvent the wheel": an MOH 'accountability' mechanism already exists

Individualized, 'block' funding, a public funding mechanism recommended by BC Supreme Court' (Auton 2000) to bring BC into compliance with the Canadian Charter of Rights and Freedoms, is not a new concept. BC government policy already exists to facilitate and administer an individualized funding mechanism for delivery of health care. Implementing such a program for autism treatment will also fulfill the Liberal 'New Era' promise: with respect to early intervention programs for children with autism, "the province must meet its legal duties under the Canada Health Act" (From BC Liberals Election Newsletter, Section: *Renewing Services for Children and Families*, Appendix A, page 4).

The Ministry of Health, in 1997, determined that palliative care — primarily amongst the aged — can be delivered in a far more cost effective manner outside government operated facilities. In other words, MOH analysis concluded that families can manage and utilize government funding more efficiently on their own, in a home-based palliative care setting.

The MOH program, *Choice in Support for Independent Living* ('CSIL') provides individualized funding for in-home palliative or longer term nursing care so that patients are able to stay in their homes as long as possible. The spouse is entrusted with management of a $36,000 (in 1997) annual budget to hire nursing and other support staff. Salient precedents of the MOH CSIL program are that it is **not means tested**, is based on an **individualized funding** mechanism, is not "cure" dependent and is in-home.

Staff in MCFD may not be aware of this flexible, cost effective MOH program, but could benefit tremendously from its quick adoption in the area of 'medically necessary' health care needs that are not provided by MCFD, MSP or MOHS.

What MCFD's 'Parent Choice' program should look like

As stated above, there are concerns amongst MCFD staff that parents may not be sufficiently responsible to utilize public funding appropriately and this negative staff 'bias' is likely an outgrowth of the type of 'customer base' social services personnel typically confronted in the course of delivering service to families. Families of children with autism do not fit this stereotyped image. They are thrust into a social services world in which they do not belong. To say that families feel they are not in the right system would be a gross understatement.

Families are subjected to MCFD policies designed for poverty and never designed to treat neurological illness based on the tenets of the Canada Health Act. Families are thrown into MCFD for no reason other than the misfortune of having a severe neurological disorder visited upon their child. A catastrophic health care scenario is what brings a family with autism into the social services world of MCFD — there is very little logic in this. The first point of contact is a social worker, rather than an autism treatment professional. An MCFD employee that typically deals with issues of poverty and other issues of social distress, is now placed in a position of authority over — and whether — a child will receive critically important, 'medically necessary' treatment for a devastating neurological disorder. Sadly, unless parents pay privately, their child goes without treatment, with SEVERE consequences for the child, the family and society.

Despite the prescription of physician specialists, required treatment continues to go unfunded by MCFD staff. MCFD staff do not truly understand the severe nature of the illness and what constitutes its most effective treatment. What little 'understanding' there is, comes from academic sources that are unqualified and not disinterested.

The new 'EIBI' program for autism intervention is the product of such collaboration between MCFD staff and local 'academe'. The program fails on three counts.

- **Not Bona Fide**: the program does not provide bona fide early, intensive behavioural treatment and lacks competent, trained EIBI service providers.

- **Not Universal Access to Health Care:** as a service designed to deliver autism health care, the EIBI pilot program fails the test of 'universal access', a central tenet of the Canada Health Act. Simply stated, it shuts out the vast majority of children whose physicians prescribe Lovaas-type intensive behavioural autism treatment.

- **Not cost Effective:** To the best of our knowledge, for each child in an the EIBI program, the EIBI contracted service provider receives $60,000 per year from MCFD to deliver 20 to 25 hours per week of intervention from grossly unqualified personnel. It is important to note that even at this high cost, government appointed service providers are not providing sufficient intensity; **an 'intensive' behavioural treatment program is defined as 40 hours per week of direct treatment.** By way of example, the Okanagan region's provider has been awarded $1.5 million to serve only 25 children ($60,000 per child). The same funding in the hands of the family can purchase *40 hours* per week of treatment supervised by highly skilled and experienced Lovaas-type Applied Behavioural Analysis professionals from a Lovaas 'replication site' that achieves a 42% normalization rate (based on recent data). This supports the contention that government is less efficient in delivering services than highly motivated parents who purchase services on the 'open market'. Stated simply, parents utilize 100% of funds on the purchase of quality treatment services. Government appointed service providers e.g. Okanagan, utilize only 33% to 42% of the allocated $60,000 per child towards direct service for the child (i.e. 20 to 25 hours per week @$20.00 per hour for 50 weeks = $20,000 to $25,000 of 'direct service'). A 42% efficiency rating would not sell many home heating furnaces, but apparently the EIBI program has been sold by MCFD special needs policy staff as an efficient and effective use of taxpayer dollars.

In view of the EIBI program's severe shortcomings, and until such time as authority over autism treatment is transferred to MOHS, the most cost effective way in the short term to deliver public funding for *effective*, medically necessary autism treatment is a parent choice program based on individualized funding.

Below is a model for such a program, patterned after MOH's 'CSIL' program for individualized funding. It is a pro forma 'Parent Information Package' to illustrate how the Choices in Autism Treatment ('CIAT') program works.

It is important to stress that a hallmark of CIAT (as in CSIL) is that it has stringent guidelines for full financial accountability. The standards are more than adequate to address MCFD concerns regarding the beneficial allocation of funds. As stated above, the

CIAT Program is based on the CSIL Program which is a Ministry of Health program designed to deliver palliative care in the patient's home, administered by the healthy spouse. An elegant method to ensure accountability for funds was developed to ensure that the moneys provided to the spouse were used appropriately for the patient.

The CIAT Program has taken these basic principles and adapted them for a parent to administer a treatment program for an autistic child. The accounting procedures are closely followed and the forms for the CIAT Program mirror the forms for the CSIL Program which appears in Appendix B of this report. Adapting the Ministry of Health model for individualized funding will give parents necessary choice in deciding who will treat their child, not unlike the choice all British Columbians now enjoy who will be their child’s physician.

********* SAMPLE CIAT INFORMATION PACKAGE *********

Choices in Autism Treatment
(CIAT PROGRAM)

PARENT INFORMATION PACKAGE

I. INTRODUCTION

A. OVERVIEW OF THE CIAT PROGRAM

The Choices in Autism Treatment (CIAT) Program is a direct funding program which enables eligible individuals to purchase their own child's autism treatment services. This specialized program places responsibility for the management and coordination of autism treatment services on the parent. At the same time, the CIAT Program affords a greater degree of flexibility, choice and autonomy in the management of your child's autism treatment program.

This section identifies the major areas of responsibility and requirements of parents who wish their child to participate in the CIAT Program. As the employer of your own therapy team, which includes your child's consultant and therapists, you will contract with, recruit, fire, train, schedule, and supervise your employees and/or contractees, and administer funds to pay them. You will need to be aware of responsibilities and requirements regarding:

- The contract/contractor or employee/employer relationship;
- Compliance with Employment Standards and Workers Compensation Board, if relevant;
- Compliance with Revenue Canada requirements, if relevant;
- maintenance of employment and/or contracts and financial records

As a CIAT Program participant, and an employer/contractor you will be responsible for obtaining the relevant forms, kits, and other information required to be an employer/contractor. Under the terms of the Labour Code, CIAT employers are classified as "labour contractors".

A business license is not required for you to hire your therapy team.
You may not pay a family member out of CIAT funds.

B. APPLICATION PROCESS

What is involved in the application for direct funding? The following steps describe the application process:

1. Send in a copy of your child's autism diagnosis made by a licensed B.C. Pediatrician, Psychiatrist or Psychologist along with a signed copy of the CIAT contract between the government and yourself. (See Appendix B, page 25). The contract must be signed and witnessed;

2. Open a separate CIAT bank account;

3. Complete the Electronic Transfer, or Direct Deposit form making sure that your social insurance number is included (See Appendix B, page 20);

4. Obtain the relevant kits, forms, and other information routinely required to be a contractor or employer;

5. Begin the process of recruitment of your autism treatment consultant and therapy team;

6. Once the necessary documents have been received by the Director of the CIAT program and you have constituted your treatment team, your start date on the CIAT program will be confirmed.

What is the role of the Case Manager?

You are the Case Manager of the program. You are responsible for the quality of your child's treatment program, designed by your qualified autism treatment consultant and overseen by your extended medical team (Pediatrician and/or Psychiatrist, and Psychologist).

C. EMPLOYER RESPONSIBILITIES AND REQUIREMENTS

Please refer to Appendix B, page 6 on information regarding the Employment Standards Act and Regulations for all therapists who are considered "employees".

This section addresses the rules for consultants and therapists who are self-employed. This needs to be addressed in order to instruct parents to pay these contracted treatment providers properly. ‘Consultants’ are never "employees" but rather act as self-employed professionals. ‘Therapists’ are generally employees with all the various deductions taken at source (i.e. WCB, UI, CPP) if they work more than 15 hours a week with a family. If they work less than this amount, most prefer to act as self-employed, ‘para-professionals’.

D. FINANCIAL REPORTING REQUIREMENTS

1. Employment and Financial Records:

The parent must set up proper employment records and an accounting system. There are many software packages on the market that would work well for CIAT Program participants. The Business Information Centre of the Ministry of Small Business, Tourism and Culture suggests Simply Accounting; however, any accounting package for small businesses that has payroll capability will do. It is up to the parent to choose how to set up the books; however, it is still recommended that the parent contact a qualified accountant for information and assistance. The CIAT program budgets for accounting and bookkeeping services if the parent wants to delegate this function.

II. Separate Bank Account:

The employer/contractor must open a separate bank account for government funds only. It must be a checking account, and one that issues monthly statements. The government will make payments to the account by direct deposit (EFT or Electronic Funds Transfer). To arrange for direct deposit of funds into your CIAT account, use the Direct Deposit (EFT) Payment Request form provided in Appendix B, page 20. It takes four to six weeks to set up the direct deposit system, so you will probably receive your first two cheques in the mail.

A sample VOID cheque is also required. No bank cards shall be issued on this account.

E. OTHER USEFUL INFORMATION

1. Payroll/Bookkeeping:

Payroll services to assist you with payroll deductions for your employees are an allowable expense. A good resource is the Yellow Pages. Look under Bookkeeping and under Payroll Services. You cannot expense more than $100 per month for payroll/bookkeeping services (aside from the first month where you may expense up to $500 for original payroll set-up fees).

Or, the employer can do his/her own routine bookkeeping, payroll including cheques, by using systems such as Simply Accounting as noted above. These can be customized to the employer's needs and are quite easy to use. See Yellow Pages under Accounting and Bookkeeping Systems. As of September 2001, these systems cost approximately $150.00 (1996 cost) including package of forms, cheques, etc.

II. Hourly Rates and Benefits:

The following amounts for hourly rates and benefits are **guidelines only:**

- The going rate for junior or line therapists ranges from $9.00 per hour to $12.00 per hour depending upon experience and geographic area.

- The going rate of experienced or lead therapists ranges from $12.00 per hour up to $20.00 per hour depending upon experience and geographic area.

- The going rate for qualified consultants stationed in B.C. ranges from $60 per hour to $120 per hour.

- The going rate for qualified consultants outside of British Columbia is $2250 to $3000 per two day workshop (plus airfare, hotel, per diem, car rental).

II. GUIDELINES FOR FINANCIAL REPORTING

The purpose of the funds provided to you under the Choices in Autism Treatment (CIAT) Program are to allow you to pay the wages of therapists and a consultant. The separate bank account you establish will show the funds coming into the account and amounts for the worker's wages going out.

The funds are under your direction and you are responsible for their appropriate use. Because they are government moneys, under your administration for a specific purpose, Revenue Canada should not consider them as income and you should not be taxed on them.

Monthly financial reporting is a contractual obligation. Financial reports must be received by the CIAT Director by the end of the following month (e.g. June's statement must be received by the first week of August).

What type of Account should be used?

The type of separate account that you set up exclusively to receive and administer CIAT funds has three requirements:

- It must be a chequing account;
- It should send you a statement every month, so you can send a copy to the CIAT Director. If there is a reason you cannot set up a chequing account with a statement each month, then a photocopy of your pass book is acceptable, but it must be included every month; and
- It should NOT have a bank card issued on the account. All transactions must be made by cheque in order to record all activity on the account by this means.

What expenses are allowable?

There is a limited range of expenses that are allowable on this account and they include:

- wages and benefits;

- ‘want ads’ to hire a therapist;
- deductions to Revenue Canada and Workers Compensation Board;
- accountant, bookkeeper or payroll service expenses to assist you with managing your money and financial reports if necessary;
- reasonable orientation costs related to training a new therapist;
- administrative expenses including office supplies and photocopying costs for required CIAT forms and documents;
- autism therapy materials

RECEIPTS ARE MANDATORY FOR YOU TO CLAIM EXPENSES!

If you are in doubt as to what is an allowable expense, please contact the Director of the CIAT Program before you make the purchase.

<u>What are some of the non-allowable expenses?</u>

- computers, computer repairs;
- food costs for therapists

<u>Client Costs</u>

Children from diagnosis up to Kindergarten are authorized 160 hours per month of one-on-one treatment, 20 hours of that time being spent with the lead therapist. In addition, the child's program may spend up to 16 hours a month of direct supervision by the consultant, and an additional 4 hours of clinic meetings a month, headed by the consultant.

An example of the expenses for the month using the above criteria for a new team:

Junior therapists:	140 hours x $10 = $1400
Lead therapist:	20 hours x $18 = $360
Consultant:	20 hours x $120 = $2400
Monthly team meeting salaries:	$232 = $232

Materials: $100 = $100

Total: $4492

An example of the expenses for the month using the above criteria for an experienced team:

Junior therapists: 140 hours x $12 = $1680
Lead therapist: 20 hours x $20 = $400
Consultant : 20 hours x $120 = $2400
Monthly team
meeting salaries: $272 = $272
Materials: $100 = $100

Total: $4852

Once the child reaches kindergarten, for those children who still require treatment, the hours generally decrease to 30 hours a week or less, depending upon the physician and consultants' recommendation based on the progress of the child.

An example of the expenses for the month using the above criteria for an experienced team for a child in kindergarten who still needs intensive treatment:

Junior therapists: 100 hours x $12 = $1200
Lead therapist: 20 hours x $20 = $400
Consultant : 20 hours x $120 = $2400
Monthly team
meeting salaries: $272 = $272
Materials: $100 = $100

Total: $4372

Once the child reaches Grade 1, for those children who are attending school full-time but still require treatment, the hours decrease once again depending upon the pediatrician and consultants' recommendation, based on the progress of the child. There will be a subset of children who will already have graduated out of the CIAT program if they have overcome the disorder. For those who do not, most will require approximately 20 hours a week of treatment.

An example of the expenses for the month using the above criteria for an experienced team for a child in Grade 1 or higher who still needs treatment:

Junior therapists:	60 hours x $12 = $720
Lead therapist:	20 hours x $20 = $400
Consultant :	8 hours x $120 = $960
Monthly team meeting salaries:	$272 = $272
Materials:	$100 = $100
	Total: $2452

There is a subset of children who still require intensive treatment and will not be ready to attend school full-time. For these few children, the therapy hours will be considerably higher.

NOTE: THESE ARE GUIDELINES ONLY SINCE EACH PARENT IS GIVEN THE FLEXIBILITY TO PAY THERAPISTS AND CONSULTANTS BASED ON THE WAGES IN THE MARKETPLACE.

Accumulating Surplus Funds:

The parent who accumulates surplus funds will be able to use those funds to increase the therapy hours of their school aged child during the summer based on the pediatrician, psychiatrist, psychologists or consultants' recommendations. Any funds that are not used on therapy by the end of the fiscal year will be retrieved by the Director of the CIAT Program. Surplus funds are routinely reviewed at the end of the calendar year. In addition, any surplus funds that are accumulated because the child no longer requires therapy will be retrieved by the Director of the CIAT Program, based on a letter from that child's medical team.

Copies of Bank Statements and Receipts:

It is mandatory that you submit ALL copies of receipts and bank statements to the Director of the CIAT Program with your monthly financial reports.

III. RESPONSIBILITY FOR MONTHLY FINANCIAL STATEMENTS

Every month you are responsible for completing a monthly financial statement for the CIAT Program. The first part of the form is the Monthly Financial Reconciliation. See Appendix B, page 24 for the Monthly Financial Form. This part of the form documents the cash balance from last month, the funds that were disbursed during the month, and the balance left over. The second part of the form documents the amount of Surplus Funds accruing to the account. The third part of the form is a Bank reconciliation. In this part of the form, the balance of the account, the outstanding deposits and the outstanding cheques must be documented to make sure that it matches the amount of the Cash Balance. Using this accounting procedure, the government is able to account for the money used for your child's treatment program. This monthly statement is best done by a bookkeeper, hired by you to track your child's therapy expenses.

Please see Appendix B of this report, page 15, for details on the accounting rules.