PSAC Family Care Expense Claim Form

Complete <u>all</u> sections to ensure payment of claim.
The following information is for PSAC use only and will remain confidential.

MEMBER INFORMATION			
LAST NAME	FIRST NAME	PSAC MEMBERSHIP NUMBER	
STREET ADDRESS		CITY	PROVINCE
POSTAL CODE	TELEPHONE NUMBER	ACTIVITY DATE	
PSAC ACTIVITY (TITLE OF CONFERENCE, COURSE, MEETING, ETC. – PLEASE SPECIFY)			

CAREGIVER INFORMATION	
CARE PROVIDED BY ☐ UNLICENSED AGENCY/CAREGIVER ☐ LICENSED AGENCY/CAREGIVER	LICENSE NUMBER
CAREGIVER/AGENCY NAME	
MAILING ADDRESS	TELEPHONE NUMBER

SECTION A – FEES INCURRED (SEE COST COMPENSATED, SECTIONS 1 & 2 FOR APPLICABLE RATES)				
FAMILY MEMBER & RELATION	AGE	DATE(S)	HOURS	FEES PAID
Example. Adam (Son)	11	Friday Saturday	7:30-9:00 16:00-17:30 7:30-17:30 17:31-7:29	$15 $15 $50 $30
1.				
2.				
3.				
			TOTAL COST (SECTION A)	

If additional space is required, use separate sheet and attach to this claim.

SECTION B – PRE-APPROVED EXCEPTIONS		
SPECIFY		
	TOTAL COST (SECTION B)	
x		
PRE-APPROVED BY	DATE	

Attach all supporting documents and receipts.

☐ I certify that the above claimed expenses were incurred as a direct result of attending an authorized **PSAC** activity.

x	
MEMBER SIGNATURE	DATE

SECTION C – APPROVAL (PSAC INTERNAL USE ONLY)		
EXPLANATORY NOTES	TOTAL CLAIM (SECTIONS A + B)	
	RECOMMENDED FOR PAYMENT	
x		
APPROVED FOR PAYMENT BY	DATE	