

To receive your reimbursement in 10 days or less, one Reimbursement Claim form is to be completed per child. Reimbursement Claim forms should be submitted at least once a month. If a receipt is for more than one child, then the receipt must be split. Do not use this form to submit a claim for a child in care with Mi'kmaq Family and Children's Services.

Invoice Number: (For Office Use Only)	<input type="text"/>
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### 1. Enter the claim period

Claim date, **from** (dd/mm/yyyy):  Claim date, **to** (dd/mm/yyyy):

### 2. Select one of the following

Payment to be made to:  Primary Foster Parent or  Respite Provider

### 3. Identify the office/agency location closest to you

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Amherst (Cumberland)    | <input type="checkbox"/> Halifax         | <input type="checkbox"/> Sydney          |
| <input type="checkbox"/> Bridgewater (Lunenburg) | <input type="checkbox"/> New Glasgow     | <input type="checkbox"/> Windsor (Hants) |
| <input type="checkbox"/> Dartmouth               | <input type="checkbox"/> Port Hawkesbury | <input type="checkbox"/> Yarmouth        |

### 4. Provide Foster Parent or Respite Provider details (as selected in section 2)

Name:

Mailing Address:  City:

Postal Code: , Nova Scotia Telephone: (xxx-xxx-xxxx):

Preferred method of contact:  Telephone or  E-mail:

### 5. Provide Child details

Child's Case ID:  Child's First Name, Last Initial:

Name of Primary Foster Parent (if not listed in section 4):

### 6. Provide reimbursement details

**Part A:** Provide mileage details (reimbursement at \$0.4615 per kilometer)

*continued on page 2*

#	Date incurred (dd/mm/yyyy)	Travel Location (From - To) (Enter Street Address e.g. 123 Main Street, City)	Description of Purpose	# of Kilometers	Amount Claimed (# Kms x \$0.4615)	Amount Approved (For Office Use Only)
1						
2						
3						
4						
5						
6						
7						
8						
9						
10						
11						
12						
13						
14						
15						
16						
17						
18						
19						
20	<b>Less Auto Payment:</b>					
<b>Sub-total for Part A (kilometer) (code 053):</b>						

Invoice Number:   
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**PART B: Provide other child maintenance expenses (not including respite)**

#	Date Purchased (dd/mm/yyyy)	Type of Reimbursement Expense (e.g. Recreation, Babysitting, etc.)	Description of Reimbursement Expense	Expense Amount or Sub-total (a)	Amount Received by Auto Payment (b)	Amount Claimed (a) - (b)	Amount Approved (For Office Use Only)	Pay Code (For Office Use Only)
1								
2								
3								
4								
5								
6								
7								
8								
9								
10								
11								
12								
13								
14								
15								
16								
17								
18								
<b>Sub-total for PART B (Other Expenses):</b>								

**Subtotals Workspace (For Office Use Only)**

Type of Expense	Total Expense	Less Auto Payment	Total		Pay Code

Invoice Number:  
(For Office Use Only)

**PART C: Provide respite details**

**Temporary short-term placement as per section 9.5.7 (20d) of the Maintenance and Expenditure for Children in Care Policy**

**START date:**  **START time:**  **END date:**  **END time:**   
 (date format: dd/mm/yyyy) (time format: hh:mm am/pm) (date format: dd/mm/yyyy) (time format: hh:mm am/pm)

Respite Provider:

Type	Description	Rate (a)	# of Days (b)	Total Expense (a)x(b)=(c)	Amount Received by Auto Payment (d)	Amount Claimed (c)-(d)	Amount Approved (For Office Use Only)
Respite full day	24 hours	\$56.00					
Respite half day	12 hours	\$28.00					
Respite quarter day	6 hours	\$14.00					
Daily board rate	Age 0-9 years	\$19.00					
Daily board rate	Age 10+ years	\$27.50					
Special Needs Rate (enter rate)							
Sub-total							

**START date:**  **START time:**  **END date:**  **END time:**   
 (date format: dd/mm/yyyy) (time format: hh:mm am/pm) (date format: dd/mm/yyyy) (time format: hh:mm am/pm)

Respite Provider:

Type	Description	Rate (a)	# of Days (b)	Total Expense (a)x(b)=(c)	Amount Received by Auto Payment (d)	Amount Claimed (c)-(d)	Amount Approved (For Office Use Only)
Respite full day	24 hours	\$56.00					
Respite half day	12 hours	\$28.00					
Respite quarter day	6 hours	\$14.00					
Daily board rate	Age 0-9 years	\$19.00					
Daily board rate	Age 10+ years	\$27.50					
Special Needs Rate (enter rate)							
Sub-total							

Invoice Number:   
(For Office Use Only)

**START date:**  **START time:**  **END date:**  **END time:**   
 (date format: dd/mm/yyyy) (time format: hh:mm am/pm) (date format: dd/mm/yyyy) (time format: hh:mm am/pm)

Respite Provider:

Type	Description	Rate (a)	# of Days (b)	Total Expense (a)x(b)=(c)	Amount Received by Auto Payment (d)	Amount Claimed (c)-(d)	Amount Approved (For Office Use Only)
Respite full day	24 hours	\$56.00					
Respite half day	12 hours	\$28.00					
Respite quarter day	6 hours	\$14.00					
Daily board rate	Age 0-9 years	\$19.00					
Daily board rate	Age 10+ years	\$27.50					
Special Needs Rate (enter rate)							
Sub-total							

**START date:**  **START time:**  **END date:**  **END time:**   
 (date format: dd/mm/yyyy) (time format: hh:mm am/pm) (date format: dd/mm/yyyy) (time format: hh:mm am/pm)

Respite Provider:

Type	Description	Rate (a)	# of Days (b)	Total Expense (a)x(b)=(c)	Amount Received by Auto Payment (d)	Amount Claimed (c)-(d)	Amount Approved (For Office Use Only)
Respite full day	24 hours	\$56.00					
Respite half day	12 hours	\$28.00					
Respite quarter day	6 hours	\$14.00					
Daily board rate	Age 0-9 years	\$19.00					
Daily board rate	Age 10+ years	\$27.50					
Special Needs Rate (enter rate)							
Sub-total							
<b>Total for PART C (Respite) (Code703):</b>							

**7. Total amounts claimed and reimbursed**

Totals	Claimed	Approved
Part A: Mileage (Code 53)		
Part B: Other Expenses		
Part C: Respite (Code 703)		
<b>Grand Totals</b>		

Invoice Number:   
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**8. Sign and date form**

Unless otherwise indicated, the Department of Community Services will contact you via E-mail using the address provided in Section 4 or on the Online Tool if any additional information is required in the processing of your request.

I confirm that the information I have provided is accurate and true. I understand that I am required to provide proof of expenditures.

I agree

Date (dd/mm/yyyy):

*Signature or Name of Foster Parent or Respite Provider ('Name' only if submitted electronically)*

**9. Comments and approval (For Office Use Only)**

Financial Clerk

Supervisor

Approval of Supervisor

I approve this reimbursement request as per the Maintenance and Expenditure for Children in Care Policy (Policy 94)

Date (dd/mm/yyyy):

*Signature or Name of Supervisor ('Name' only if submitted electronically)*

**For Office Use Only**

Invoice Number	Clerk Initial	Date Entered