Child, Youth and Family Supports
Foster Parent/Respite Provider Reimbursement Claim

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'kmaw Family and Children's Services.

Invoice Number: (For Office Use Only) ______

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

☐ Amherst (Cumberland) ☐ Halifax ☐ Sydney

☐ Bridgewater (Lunenburg) ☐ New Glasgow ☐ Windsor (Hants)

☐ Dartmouth ☐ Port Hawkesbury ☐ 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 $0.5113 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 $0.5113)	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				**Less Auto Payment:**	**$50.00**	
				Sub-total for Part A (kilometer) (**code 053**):		

Invoice Number: (For Office Use Only)

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								
Sub-total for PART B (Other Expenses):								

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: (date format: dd/mm/yyyy) **START time:** (time format: hh:mm am/pm) **END date:** (date format: dd/mm/yyyy) **END time:** (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	$34.00					
Daily board rate	Age 10+ years	$42.50					
Special Needs Rate (enter rate)							
					Sub-total		

START date: (date format: dd/mm/yyyy) **START time:** (time format: hh:mm am/pm) **END date:** (date format: dd/mm/yyyy) **END time:** (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	$34.00					
Daily board rate	Age 10+ years	$42.50					
Special Needs Rate (enter rate)							
					Sub-total		

Invoice Number: (For Office Use Only)

Child, Youth and Family Supports
Foster Parent/Respite Provider Reimbursement Claim

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	$34.00					
Daily board rate	Age 10+ years	$42.50					
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	$34.00					
Daily board rate	Age 10+ years	$42.50					
Special Needs Rate (enter rate)							
					Sub-total		
					Total for PART C (Respite) (**Code703**):		

7. Total amounts claimed and reimbursed

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

Invoice Number: (For Office Use Only) ______

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