

TEMAGAMI FIRST NATION ENRICHMENT FUNDS

After Care Claim Form

This form must be signed and complete in full. **If incomplete, it will be returned to you**, which will delay the processing of the claim.

Contact Information

Client Name (Main Contact)	Date of Birth	Band Number
Mailing Address		Postal Code
Email Address		Phone/Cell Number

Please list below type of expenses/ associated costs:

Coverage	Fixed Rates	Date(s)	Description of Service	Name of Service Provider
Transportation	16.5 / km			
Companion and/or care-sitter	\$35.00/day and/or \$20.00.night			
Family respite	\$35.00/day and/or \$20.00.night			
Homemaking service: Meal Prep/cleaning/ shop/laundry	\$15.00 /hr.			
Infant & childcare	\$25/day or \$50/day 2 or more			
Alternate level of care	One-time payment		Chronic care co-payment	

Verification: By signing below, I certify that the information is true and accurate.

I also understand that if any funds are not used for the purposes outlined, the money will be owed back to the Enrichment Fund program.

Signature

Date

Mail completed form and **ORIGINAL RECIEPTS** to:
 Doreen Potts Health Centre
 Temagami First Nation
 Bear Island, ON P0H 1C0
 Attention: **Office Manager** Enrichment Funds Claim
 Inquiries: (705) 237-8900 or Toll-Free at 1-866-262-2862