



**INVOICE REIMBURSEMENT FORM - SAMPLE**  
**(Funding Transfer Form)**

Extend-A-Family  
91 Moore Ave  
Kitchener, ON N2H3S4  
invoices@eafwr.on.ca

Name of the Person Receiving the Funding

Name of the Primary Caregiver

Person Supported: **Kelly Moran**  
(First and Last Name)

Family Name: **Benjamin Sarachman**  
(First and Last Name)

Address: **12 Fake Street, Kitchener, ON**

EAFWR Coordinator: **Laura Williams**

Funding Source:  SSAH  Passport  Enhanced Respite/MFTD  Other: \_\_\_\_\_

**Instructions:**

Funding Type for These Expenses

- Always use this page as the first page for reimbursement of any invoices/receipts.
- Signatures, invoices or receipts are required for ALL reimbursements.
- All banking information must be provided in advance, including service providers.

Total Of What The Family Has Paid For

**Reimbursement Direction:**

Who Do We Pay?		Name	Amount
A	Total Reimbursement to <b>Family:</b>	Benjamin Sarachman	<b>\$858</b> <span>Total Family Paid</span>
B	Total Reimbursement to <b>Person Supported:</b>		\$
C	Total Reimbursement to <b>Service Provider (ex. private respite worker, camp, housecleaner, program provider):</b>	Kevin Scala	<b>\$225</b> <span>Direct Pay</span>
D	Total Reimbursement to <b>2<sup>nd</sup> Service Provider:</b>	Camp Rainbow Sunshine	<b>\$500</b> <span>Direct Pay</span>
E	Total Reimbursement to <b>3<sup>rd</sup> Service Provider:</b>	Expert Cleaning Person	<b>\$200</b> <span>Direct Pay</span>
<b>Total of All Reimbursement</b>		(A + B + C + D + E)	<b>\$1783</b>

**Signature:**

Name of the Person Signing

I, \_\_\_\_\_, hereby acknowledge and agree that the Service Provider(s)  
(Name of Person Supported/family, please print)  
have provided these services to the Person Supported in accordance with funding guidelines.

Check only if EAFWR will be paying service providers directly on your behalf

I authorize to pay THE TOTAL FEES indicated above to the Independent Service Provider(s) directly using my available funding administered by EAFWR pursuant to my FUNDING SERVICE AGREEMENT with EAFWR. I furthermore agree that I will cover any portion of the fees that exceed the available funding.

Person Supported /Family Signature

Date

Signature must be completed

Person Supported:

**Kelly Moran**  
(First and Last Name)

Family Name:

**Benjamin Sarachman**  
(First and Last Name)

**RESPIRE / SUPPORT WORKER**

Please put names on each page submitted

Direct Pay  
Family Paid

Dates of Service	# of Hours	Hrly Rate	Amount Paid	Respite / Support Worker		
				Print Name	Phone Number	Signature *
October 1 – 5	10	\$20	\$200	Kevin Scala	519 555 1234	<i>Kevin Scala</i>
October 5 – 10	4	\$10	\$40	Michelle Guay	519 555 1235	<i>Michelle Guay</i>
October 5 – 10	4	\$15	\$60	Grandma Moran	519 555 1236	<i>Grandma Moran</i>
<b>TOTALS</b>	<b>18 hrs.</b>		<b>\$ 300</b>			

Total hours and cost for ALL providers

\* I acknowledge and agree that I am an independent service provider and I have provided services as described above to the Person Supported as agreed with the Designate and am solely responsible for the quality, appropriateness and safety of such services. I furthermore agree that I am not in an employment relationship with the Person Supported/Designate, or any other entity in respect of the services to the Person Supported. I am responsible for reporting my own earnings, maintaining my own records regarding the funds transferred to me, making any remittances, paying any taxes, maintaining my own insurance in respect of any injuries I may sustain while performing the services. I hereby agree to release, hold harmless and indemnify the Person Supported/Designate and any agent, or Transfer Payment Agency acting on behalf of or supporting the Person Supported or the Designate, in respect of any harm, loss, claim, cause of action, fines, penalty, demand, interest, costs or liability that may arise as a result of or in relation to my performance of the services. I also acknowledge that the Designate may pay this invoice by directing a Transfer Payment Agency to issue payment to me on his/her/their behalf.

If you are only using private support people, only submit page 1 and 2

Person Supported:

**Kelly Moran**

Family Name:

**Benjamin Sarachman**

(First and Last Name)

(First and Last Name)

For Private Support Providers

**TRANSPORTATION** (Mileage, {Bus Pass/Taxi – Passport funding only})

	Type of Service	Dates of Service	Kms	Total	Service Provider	
					Print Name	Signature or Receipt ✓
Family Paid	Mileage	Oct 5 – 10	20 @ 0.40	8.00	Michelle Guay	Michelle Guay
Direct Pay	Mileage	Oct 1 - 5	50 @ 0.50	25.00	Kevin Scala	Kevin Scala
		TOTAL	70 km	\$ 33.00		

Total cost for ALL transportation

**CAMP**

	Camp Name	Camp Dates	Cost	Receipt Attached ✓
Direct Pay	Camp Rainbow Sunshine	July 21 – 25, July 28 – 31	\$500	Yes
		TOTAL	\$500	

Total cost for ALL camps

**REGISTRATION FEES FOR PROGRAMS, or MEMBERSHIPS** (i.e. Hockey, Swimming, Music)

	Registrations	Dates of Service	Cost	Receipt Attached ✓
Family Paid	10 Music Lessons	October 1 – November 30	\$500	Yes
	3 month YMCA Membership	October 1 – December 31	\$250	Yes
		TOTAL	\$750	

Total cost for ALL programs, memberships and lessons

Person Supported: **Kelly Moran**  
(First and Last Name)

Family Name: **Benjamin Sarachman**  
(First and Last Name)

**SSAH or ENHANCED RESPITE/MFTD FUNDING USE ONLY, LIGHT HOUSEKEEPING/YARD WORK**

	Type of Service	Dates of Service	Cost	Service Provider	
				Print Name	Signature or receipt ✓
Direct Pay	House cleaning	Oct 1	\$50	Expert Cleaning Person	<i>Expert Cleaning Person</i>
	House cleaning	Oct 7	\$50	Expert Cleaning Person	<i>Expert Cleaning Person</i>
	House cleaning	Oct 14	\$50	Expert Cleaning Person	<i>Expert Cleaning Person</i>
	House cleaning	Oct 21	\$50	Expert Cleaning Person	<i>Expert Cleaning Person</i>
	<b>TOTAL</b>		<b>\$ 200</b>		

These are funding specific expenses. Only use the box for the funding type you currently have

**PASSPORT FUNDING USE ONLY, ACTIVITIES**

Type of Activity (i.e. Movies, Tickets, Events)	Dates of Service	Cost	Receipt Attached ✓
	<b>TOTAL</b>		<b>\$</b>