



**PASSPORT REIMBURSEMENT FORM
(Funding Transfer Form)**

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

Person Supported: _____ Family Name: _____
(First and Last Name) (First and Last Name)

Address: _____ EAFWR Coordinator: _____

Instructions:

- 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 to your Support Coordinator in advance, including service providers.
- **For additional instructions and resources for filling out this form please visit <https://www.eafwr.on.ca/wp-content/uploads/2018/01/ISP-How-to-Get-Reimbursed.pdf> .**
- Submit invoices electronically at: invoices@eafwr.on.ca

Reimbursement Direction:

	Who Do We Pay?	Name	Amount
A	Total Reimbursement to Person Supported/Family:		\$
Amounts Entered Below are Payable Directly to the Service Providers (Contact your support Coordinator in advance to arrange for a Service Provider to be set-up as a payee.)			
B	1st Service Provider:		\$
C	2nd Service Provider:		\$
D	3rd Service Provider:		\$
	Total of All Reimbursement	(A + B + C + D)	\$

Signature:

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.

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

Person Supported: _____
 (First and Last Name)

Family Name: _____
 (First and Last Name)

RESPIRE / SUPPORT WORKER

Dates of Service	# of Hours	Hrly Rate	Amount Paid	Respite / Support Worker		
				Print Name	Phone Number	Signature *
TOTALS	hrs.		\$			

* 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.

Person Supported: _____
 (First and Last Name)

Family Name: _____
 (First and Last Name)

ACTIVITIES AND EVENTS

Name of Service Provider	Dates of Service	Cost	Receipt Attached ✓
TOTAL		\$	

CAMPS

Name of Service Provider	Dates of Service	Cost	Receipt Attached ✓
TOTAL		\$	

Person Supported: _____
 (First and Last Name)

Family Name: _____
 (First and Last Name)

PROGRAMS AND MEMBERSHIPS

Name of Service Provider	Dates of Service	Cost	Receipt Attached ✓
TOTAL		\$	

TRANSPORTATION (Mileage, {Bus Pass/Taxi})

Type of Service/Provider	Dates of Service	Kms	Total	Service Provider	
				Print Name	Signature or Receipt ✓
TOTAL		kms	\$		