# VT/VSEA

## 2023 Elder Care Cost Reimbursement Application

Name of Applicant: _____

Employee ID#: _____ Department: _____

Email Address: _____ Work Phone: _____

Mailing address: _____

Check One: Full-Time, or Part-Time, work at least 20 hours per week (average) FT☐ PT☐

Amount of reimbursement you are requesting (Minimum $50/Maximum $500): $_____

Information regarding the family member who will benefit from this reimbursement request:

Name: _____

Address: _____

Date of Birth: _____

Your Relationship to this Family Member: _____

Please provide a description of this request.

_____

_____

_____

If this request is for reimbursement of mileage expense, please complete, date, and sign the attached VT/VSEA Elder Care Mileage Chart form, beginning on Page 3, below.

If this request is for reimbursement of payment to an individual person who was paid for services, please complete date and sign the attached VT/VSEA Elder Care Receipt form. This form must also be dated and signed by the person who provided the services.

I hereby authorize the VT/VSEA Child & Elder Care Committee to use and disclose any protected health information described on this application form to the Committee Administrator. I understand that I have the right to revoke this authorization, in writing, at any time.

I certify that the above information and the information attached are accurate.

Employee Signature: _____ Date_____

Return this application with a copy of documentation of expenses incurred, such as receipts or cancelled checks.

Mail this application (and any required documentation above), via the US Postal Service to:

VT/VSEA Child & Elder Care Committee
PO Box 105
Huntington, VT 05462

**or**

Submit electronically to vtchildelder@vsea.org

Note: If mailing this application, must be postmarked by December 31, 2023, and mailed to us via the US Postal Service as noted above. Electronic applications must be submitted by 11:59 pm on December 31, 2023.

**VT/VSEA Elder Care Mileage Chart**

Completed mileage charts can be submitted by mail or electronically with the reimbursement application.

Please provide details regarding mileage for transporting elder relative to and from medical appointments.

**Minimum of 100 miles, per roundtrip**, bust be driven before you can apply for reimbursement. Please use additional pages if the total number of trips will not fit on one page.

| Date | From | To | Purpose | Mileage |
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I certify that the above information is accurate.

Employee Signature: _____ Date: _____

Employee Name (please print): _____

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Employee Signature: _____ Date: _____

Employee Name (please print): _____