VT/VSEA Elder Care Cost Reimbursement Application

Name of Applicant:
Employee ID#: Department:
Email Address: Work Phone: Mailing address:
Circle One: Full-Time, or Part-Time, work at least 20 hours per week (average)
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.
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: DateReturn this application with a copy of documentation— of expenses incurred, such as receipts or cancelled checks.

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

Email this application to VTchildelder@vsea.org (and any required documentation above), or

mail via the US Postal Service to:

Note: Must be postmarked by December 31, 2024 and mailed to us via the US Postal Service as noted above. Any other type of submission will not be accepted. Applications that are emailed must be sent by 11:59 pm to VTchildelder@vsea.rog on December 31, 2024.