Ryan White HIV/AIDS Treatment Extension Act
Boston EMA HIV Health Services Planning Council
c/o Planning Council Support
1010 Massachusetts Ave, 2nd Floor I Boston, MA 02118
Phone: 617.534.5611 I Fax: 617.419.1340

Childcare Reimbursement Request Form

Planning Council (PC) Member Information	
Last Name:	
First Name:	

Childcare Provider Information	
Provider Name:	
Phone Number:	(___ ___ ___) ___ ___ ___ - ___ ___ ___ ___

Dependent Name and Relationship to PC Member			
Dependent Name:			
Relationship to PC Member	☐ Daughter ☐ Son ☐ Qualifying Child		
Type of Childcare	☐ Babysitter ☐ Day Care Center ☐ Family Day Care ☐ **Relative Care**: ☐ Grandparent ☐ Aunt ☐ Uncle ☐ Other (_____)		
Date of Service	**Total Hour of Service**	**Amount Billed/Out-of-Pocket Cost**	
____/ ____/ ____ (MM/DD/YY)	_____hrs	$ _____ , _____	
Dependent Name:			
Relationship to PC Member	☐ Daughter ☐ Son ☐ Qualifying Child		
Type of Childcare	☐ Babysitter ☐ Day Care Center ☐ Family Day Care ☐ **Relative Care**: ☐ Grandparent ☐ Aunt ☐ Uncle ☐ Other (_____)		
Date of Service	**Total Hour of Service**	**Amount Billed/Out-of-Pocket Cost**	
____/ ____/ ____ (MM/DD/YY)	_____hrs	$ _____ , _____	
Total Childcare Reimbursement	$_____		

Childcare Provider Signature: _____ Date: ____/ ____/ ____

PC Member Signature: _____ Date: ____/ ____/ ____

For PC Staff Use Only: Receipt Date: ____/ ____/ ____ PC Staff Initial: _____ Follow-up Needed: □Yes □No