Receipt Form: *Guide to Filling Out*

Blank copies of this form will be available at: www.nshealth.ca/continuing-care, under Client Forms.

Direct Funding Receipt Form

Care Recipient Name:	Substitute Decision Maker (if applicable):
Recipient Address:	Care Manager (if designated)

Date	Description of Service (e.g. meal prep)	Cost of Service

TOTAL $ ________

Service Provider, please confirm (if not providing separate receipts):

- ☑ I have provided services and received payment as outlined above.

Signature of Service Provider   Date

Care Recipient or SDM/Care Manager (if applicable/designated), please confirm:

- ☑ I have paid for the above services.
- ❑ I have attached receipts indicating the services have been paid in full.

Signature of Care Recipient of SDM/Care Manager (if applicable/designated)   Date

Return this form along with all supporting documentation to the address listed below:

Nova Scotia Health, Home First/IADL Clerk, Continuing Care,
45 Weatherbee Road, Suite LL02, Sydney, NS B1M 0A1
HomeFirstIADLClerk@nshealth.ca
1-800-225-7225

Mail or email this form(s) and receipt + the *Reconciliation Report* at the end of each quarter.

****If your funding is $500 or less,** you do not need to mail this form in, but you are encouraged to keep for your records.**