Receipt Form: *Guide to Filling Out*

NOVA SCOTIA

Direct Funding Receipt Form

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

Care Recipient Name:	Substitute Decision Maker (if applicable):
Fill in your full name here.	Fill in name of SDM, if one is appointed
Recipient Address:	Care Manager (if designated)
Fill in full mailing address, including PO box.	Fill in if applicable

Date	Description of Service (e.g. meal prep)	Cost of Service
Enter the dates here	State the type of service provided (examples below)	Enter amount paid
27-Feb-2024	*Housekeeping*	*$ 21.00*
28-Feb-2024	*Meal Preparation*	*$ 42.00*
29-Feb-2024	*Personal Care*	*$ 21.00*

TOTAL $ *$ 84.00*

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

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

Your service provider signs and ticks the box if they do not provide receipts. | Enter the date

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.

Sign here and select the box (above) that applies | Enter the date

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
Cape Breton Regional Hospital,
1482 George Street, Sydney, NS B1P 1P3
HomeFirstIADLClerk@nshealth.ca
1-800-225-7225

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

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