FAMILY CARE EXPENSE RECEIPT - PLEASE PRINT

TO: Union of Veterans' Affairs Employees

This will certify that I am providing care to:

Name of Member _____

For _____ person(s) for a period of _____ days, at a charge of $ _____

per person, per day. The total amount to be paid is $

Name and address of care provider:

_____

_____

_____

Signature of care provider:

_____

First Family Member	$50.00
Each Additional Family Member	25.00
Overnight	30.00