COUNTY OF SANTA CLARA FAMILY CARE EXPENSE REIMBURSEMENT REQUEST FORM

Name of Claimant: _____ **Date**: _____

Name of Brown Act Body that Claimant Serves: _____

Reimbursement is for reasonable, actual family care expenses incurred in the performance of official County duties in compliance with the County's Family Care Expense Reimbursement Policy, and **is limited to** four (4) hours per family member, per day, and may not exceed the following rates:

- For **children** (under the age of 13), the California Department of Education's published part-time hourly Average Rate for Child Care Centers in Santa Clara County. (http://www3.cde.ca.gov/rcscc/; effective 1/1/2017, **$18.61 per hour for children under 2 years of age, $14.60 for children 2 through 5, and $13.22 for children aged 6 to 13**)

- For the **aged** (65 years of age or older), **blind** or **disabled** who without the care would be unable to remain safely in his or her own home-, the hourly wage that the County of Santa County pays to providers of in-home supportive service. (https://www.sccgov.org/sites/ssa/daas/ihss/Pages/providers.aspx; effective 2/01/2016, $13.00 per hour)

Requests must be submitted to the Secretary or Clerk assigned to the County Brown Act body the member serves within 30 days from the date the expenses were incurred. **Initial** each item below to indicate each statement is true:

Initial	
	A. The expenses resulted from the performance of official County business.

Please indicate the **Date: _____ Start Time: _____ Duration: _____ Location**: _____ and the **Type** of the qualifying business activities performed **(check all that apply below)**

	Attendance at a meeting of the Brown Act body you serve
	Attendance at an inspection/site visit for Brown Act body business
	Attendance at a meeting with County staff for Brown Act body business
	Participation in Brown Act body delegation visits or special event activities

Initial	
	B. The expenses were incurred for the care of a family member who is either (1) a child (under the age of 13), or (2) aged (65 years of age or older), blind or disabled who without the care would be unable to remain safely in their home.

Initial	
	C. The provider of family care is not the Claimant's spouse or a person whom the Claimant can claim as a dependent.

Name of Family Member	**Age**	**Hours of Care**	**Name, Address, and Contact Information of Care Provider**	**Total Cost Incurred**
			Name: _____	$_____
			Address: _____	**NOTE**: This request **will not be considered** unless original / itemized receipts are included with this form.*
			_____	
			Phone: _____	
PLEASE INCLUDE ADDITIONAL PAGES AS NEEDED				

*Family Care Expense Reimbursement requires that **ORIGINAL/ITEMIZED RECEIPTS**, reflecting the actual costs incurred, be submitted with this Form. **Any of the following will be accepted as receipts**: receipt indicating who was paid and dollar amount, cash register receipt, copy of cancelled check, copy of bank statement if cancelled check is not available, or an invoice marked paid or indicated how paid (cash, check, charge, etc.).

I certify that the above is true and correct and that the amount claimed is for the reasonable and necessary expenses incurred, solely for official County business, and not personal use.

Claimant Signature: _____

Date:

Verified by:	**Date:**
Approved by:	**Date:**
SAP Vender #:	**SAP Document #:**