POGO Financial Assistance Program (POFAP)
Claim Form 2017

Child's name: ______________________________ ______________________________ Birth date: _______ /______ /_____
First name Last name Year Month Day

Reimbursement cheque to be sent to: ____
First name Last name

____
Street number Street name/RR# Apt# City Province Postal Code

Is this a new address? ☐No ☐Yes (If you have moved please use new address)

Phone number: ______________________ POFAP Number: ______________________

Child's Treatment Status:
☐ Active Treatment
(period of receiving treatment)
☐ Active Follow-up, please provide treatment end date: _____/_____/_____
Note: If Bone Marrow Transplant use discharge date. Year Month Day

See your POGO Interlink Nurse or Social Worker about when and how to submit claim forms.
CLAIMS MORE THAN 3 MONTHS OLD WILL NOT BE PROCESSED.

Date(s)	Outpatient Treatment $7.50/day	Inpatient Treatment $15/day	Accommodation RMH $10/night Other $20/night	Child Care (CC) $8/hour		Hospital*	Hospital Signature
				# of Hrs.	Total CC $		
SUB-TOTALS						**TOTAL DUE:**	

***Please indicate the hospital attended on the day of treatment by using the code letters below the chart:**

***Hospital Codes:**

Children's Hospital of Eastern Ontario (**O**)
Children's Hospital, LHSC (**L**)
Grand River Hospital (**G**)
Orillia Soldiers' Memorial Hospital (**OR**)
McMaster Children's Hospital (**H**)
The Hospital for Sick Children (**T**)
Windsor Regional Hospital (**W**)
Southlake Regional Hospital (**SL**)
Kingston General Hospital (**K**)
Northeast Cancer Centre, Health Sciences North (**S**)
Credit Valley Hospital (**C**)
Rouge Valley Centenary (**R**)
Other (**OTH**) please specify:______________________________

Parent/Legal Guardian Signature:______________________________ Date: ______ /______ /_____
Year Month Day

HOSPITAL USE ONLY: DEPT APPROVAL

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New Form: Jan 2017