POGO Financial Assistance Program Claim Form

Please complete one claim form for each month, for each treatment centre (if treated at more than one hospital). Submit the claim form at the treatment centre where the treatment occurred. Claims must be validated, by date, with the signature of the social worker or POGO Interlink Nurse at the treatment centre.

Child's name: _____ Birthdate: _____/_____/_____
Last name First name Year Month Day

Address: _____
Street number Street name/RR# Apt # City Postal Code

Phone Number: ( ) _____ Email: _____

Has this contact info changed since last claim submission: ☐ No ☐ Yes

Child's Treatment Status *(check one)*:

☐ 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

Treatment Hospital: _____ **POGO Family ID:** _____

See your POGO Interlink Nurse or social worker for more info on claim submissions.

CLAIMS MORE THAN 3 MONTHS OLD WILL NOT BE PROCESSED

Date(s)	Food Allowance		Accommodations RMH $10/night Other $20/night (Receipts required)	Child Care (CC) $8.00/hour*		Social Worker or POGO Interlink Nurse Validation
	Outpatient Treatment $7.50/day	Inpatient Treatment $15.00/day		# of Hours	Total CC$	
SUB-TOTALS						**TOTAL DUE:**

**Maximum 120 hrs/yr starting from date of first child care claim*

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

HOSPITAL USE ONLY: DEPT APPROVAL

Name: _____ Signature: _____