

**POGO Family ID:** 

## **POGO Financial Assistance Program**

Please **complete one claim form for each month**. **Submit the claim form at your child's main treatment centre** for processing. **Claims must be validated,** by date, with the signature of the social worker, resource navigator or POGO Interlink Nurse at the treatment centre.

Child's name:					Birthdate:/	
Last name			First name		Year Month Day	
Address:						
Street number	Stree	et name/RR#	·		City	Postal code
Phone Number: ( )		Email (	(mandatory):			
Has this contact info chang	ged since last	claim submis	ssion: ☐ No ☐ Yes	5		
See your social wo	orker, resourc	e navigator o	or POGO Interlink Nur	rse for more i	nfo on claim sub	missions.
CLAIMS MUST BE SUBM	ITTED WITHI	N 3 MONTH	IS FROM TREATME	NT DATE (OL	DER CLAIMS CANI	NOT BE PROCESSED)
	Food Allowance			0.11.0		
Month: Date(s)	Outpatient Treatment # of Day(s)	Inpatient Treatment # of Day(s)	Accommodations # of Nights (Receipts required)	Child Care Hours* (provided by a service)	Treatment Centre	Claim Validation**
TOTAL # OF DAYS / HOURS						
	x \$7.50/day	x \$15.00/day	x \$10/RMH or \$20/Other	x \$8.00/hr		
SUB-TOTALS					TOTAL:	
*Maximum 120 hrs/yr starting fr	om date of first	L child care claim	**Social worker_resou	l Irce naviaator oi		 rse validation required
I hereby certify that the da are provided by a child care	tes listed abov	ve are a true l	indication of treatme	ent dates and		•
Parent/Legal Guardian Sig	nature:				_ Date: Year	//
HOSPITAL USE ONLY: Social	worker / resc	ource navigato	or / POGO Interlink Nu	ırse declaratio	on	
Child's Treatment Status			-,		<del></del>	
☐ On Active Treatm		eceiving treatme	ent) 🗆 Final Tre	atment/Clain	n Date:	// Month Day
☐ Bone Marrow Tra	•	_	Year Month Day	_	Year	Month Day
Name (nlease print):			Signature:			