Child Care Inclusion: Verification of Travel, Replacement Staff, Professional Learning or Funded Space Guide to Completion

ONLY ONE PAY PERIOD CAN BE SUBMITTED PER FORM
ONLY ONE AUTHORIZATION NUMBER PER TRAVEL
ONLY ONE AUTHORIZARION NUMBER PER REPLACEMENT STAFF
ONLY ONE AUTHORIZATION NUMBER PER FUNDED SPACE

The Child Care Inclusion: Verification of Travel, Professional Learning and Replacement Staff or Funded Space form must be completed in full and be consistent with the External Invoice form in order to be processed. Incomplete, inaccurate, and/or inconsistent forms will be returned to the vendor.

Section A: Child Care Service Information

Operating Name:
The name by which the child care service is known, as indicated on the child care licence or approval certificate.

Street Address:
The street address where the child care service is physically located.

City/Town:
The town or city where the child care service is physically located.

Postal Code:
The postal code associated with the physical location of the child care service.

Section B: Vendor Payment Information

Vendor Name:
The name of the corporation to which the funds will be issued. Where a vendor is not incorporated, this should be the name of the individual to which the funds will be issued. **NOTE: This field must be completed even if the vendor address is the same as the child care service operating address.**

Vendor Number:
The number associated with the vendor name. It can be found on the **Authorization to Provide Goods/Services** form**.**

Case ID Number:
This number is found on the **Approval of Child Care Inclusion Program Support Schedule 'A'**. **Only claim ONE Case ID per invoice.**

NOTE: Where the vendor address information is the same as the operating address, this can be indicated by selecting ☐ *Same as Operating Address*.

Street Address:
The street address where the vendor receives financial correspondence from the Department. **This address must match the address on the Authorization to Provide Goods/Services form**. This field can be left blank if the street address is the same as the operating street address and it has been indicated by selecting ☐ ***Same as Operating Address*.**

City/Town:
The town or city where the vendor receives financial correspondence from the Department. **The City/Town must match the city/town on the Authorization to Provide Goods/Services form**. This field can be left blank if the city/town is the same as the operating city/town and it has been indicated by selecting ☐ ***Same as Operating Address*.**

Postal Code:
The postal code associated with the address of the vendor. **The postal code must match the postal code on the Authorization to Provide Goods/Services form**. This field can be left blank if the postal code is the same as the operating postal code and it has been indicated by selecting ☐ ***Same as Operating Address*.**

Section C: Travel, Professional Learning and Replacement Staff Information
Note: Travel and Replacement Staff payments must be recommended by the Inclusion Consultant prior to the claim being submitted. Where Travel, Professional Learning and Replacement Staff is not applicable to the services being claimed, this must be indicated by selecting ☐ *Not Applicable.*

Replacement Caregiver Name:
The name of the person replacing the caregiver who provides the inclusion support. This is to be entered as the *Last Name*, *First name*. e.g., Smith, John. **NOTE: The staff name must be consistent with staff identified on the staffing resource sheet found in the Service Agreement and the external invoice form.**

NOTE: The Verification of Replacement Staff and Travel or Funded Space form must not contain information with more than one pay period.

Date of Meeting/PL:
The date the caregiver associated with the approved inclusion support participated in an individual multi-disciplinary program planning meeting or professional learning. It is to be entered in YYYY/MM/DD format, e.g., where the date is September 28, 2018, the information must be entered as 2018/09/28.
When entering the date information on the external invoice, the 'from and to' dates should be the same date.

NOTE: Documentation verifying that the caregiver associated with the approved inclusion support participated in an individual multi-disciplinary program planning meeting or professional learning must be attached. This must be written verification from the manager/chair of the individual multi-disciplinary program planning meeting or the facilitator of the professional learning.

Location of Meeting/PL:
The street address and town where the caregiver associated with the approved inclusion support attended the individual multi-disciplinary program planning meeting or professional learning.

PL Fees:
The amount associated with participation in professional Learning relevant to the needs of the home/homeroom. The amount must be entered in currency format, e.g., $50.00. **NOTE: When using the electronic fillable version of this form this fee will automatically be calculated in the Total Travel, PL & RS Claimed.**

PL Service Authorization:
This number is found on the **Authorization to Provide Goods/Services** form. **A form with a missing or invalid Service Authorization Number(s) will be returned.**

Travel:
Service Authorization Number:
This number is found on the **Authorization to Provide Goods/Services** form. **A form with a missing or invalid Service Authorization Number(s) will be returned.**

Kilometers Traveled
The number of kilometers traveled by the caregiver who participated in the individual multi-disciplinary program planning meeting or professional learning. The distance travelled must be calculated from the child care service to the location of where the individual multi-disciplinary program planning meeting or professional learning took place. To be entered in numerical format. **NOTE: child care services can only claim the KM Traveled or a Taxi Receipt Amount NOT both.**

KM Rate
The basic rate per kilometer paid to the caregiver associated with the approved inclusion support for the use of their private vehicle to attend the individual multi-disciplinary program planning meeting or professional learning. To be entered in currency format, e.g., 34.72 ¢/km would be entered $0.3472. The basic rate is identified on the Government's website:
www.exec.gov.nl.ca/exec/hrs/working_with_us/auto_reimbursement.html

Taxi Receipt Amount:
The amount indicated on a taxi receipt received by the caregiver associated with the approved inclusion support being transported from the child care service to the location of where the individual multi-disciplinary program planning meeting or professional learning took place. The amount must be entered in currency format, e.g., $45.60. **NOTE: Services can only claim the KM Rate or a Taxi Receipt Amount NOT both.**

Travel Total:
This is the total cost of the travel calculated by the Kilometers Travelled multiplied by the KM Rate or the Taxi Receipt Amount. **NOTE: When using the electronic fillable version of this form this calculation computes automatically.**

Replacement Staff:

Service Authorization Number:

This number is found on the **Authorization to Provide Goods/Services** form. **A form with a missing or invalid Service Authorization Number(s) will be returned.**

Hourly Rate:

The hourly rate of pay for the replacement staff as identified on the paystubs. The amount must be entered in currency format, e.g., $16.45.

Hours Worked:

The total number of hours the replacement staff worked on the date the caregiver who provides the approved inclusion support was absent to attend the individual multi-disciplinary program planning meeting or professional learning. To be entered in number format, e.g., where 3 hours and thirty minutes were worked, it must be entered as 3.50

Replacement Staff Total

The total cost of the replacement staff calculated by the hourly rate multiplied by number of hours worked by the replacement staff identified. The amount must be entered in currency format, e.g., $312.45. **NOTE: When using the electronic fillable version of this form this calculation computes automatically where values have been entered in the applicable fields.**

Total Travel, PL & RS (Replacement Staff) Claimed:

The Travel Total plus the Replacement Staff Total and Professional Learning Fee. The amount must be entered in currency format, e.g., $412.45. This amount should be the same amount indicated on the external invoice form. **NOTE: When using the electronic fillable version of this form this calculation computes automatically where values have been entered in the applicable fields.**

Section D: Funded Space Information

OGP Site:

Select - Yes or No.

Pay Period:

From: This is the first day of the pay period the service was provided. It is to be entered in YYYY/MM/DD format, e.g., where September 3, 2018 was the first day in the month of September that the service was provided, the information must be entered as 2018/09/03.

To: This is the last day of the pay period the service was provided. It is to be entered in YYYY/MM/DD format, e.g., where September 28, 2018 was the last day in the month of September that the service was provided the information must be entered as 2018/09/28.

Service Authorization Number:

This number is found on the **Authorization to Provide Goods/Services** form. **A form with a missing or invalid Service Authorization Number(s) will be returned.**

Daily Rate:
The daily rate as determined by tables 1 and 2 in section ELCD-2021-SUB-G1 of the Child Care Subsidy Policy Manual. **NOTE: Where two Funded Space supports are being requested and both supports are in the same age range use the "(1)Daily Rate" field to calculate the funding amounts by entering "2" the "# of spaces" field. Where one funded support is a different age range than the other funded support (e.g., family home age ranges), complete each calculation separately by using both "(1)Daily Rate" and "(2)Daily rate" fields.**

# of Days:
The number of days as identified in the pay period field. This is to be entered in numerical format.

# of Spaces:
The number of vacant spaces being kept empty to enhance the caregiver to child ratio. This is to be entered in numerical format.

Total FS (Funded Space) Claimed:
This is the Daily Rate multiplied by the Number of Days and Number of spaces for the pay period identified. The amount must be entered in currency format, e.g., $725.78. This amount should be the same amount indicated on the external invoice form. **NOTE: When using the electronic fillable version of this form this calculation computes automatically.**

Licensee/FCC Provider/Authorized Designate (please print):
The printed name of the licensee/FCC Provider or authorized designate who signed the form in the next field. Every effort should be made to ensure the name is legible. **NOTE: the form will be returned where the name is missing from this field.**

Signature:
This is the signature of the individual identified as the licensee, FCC provider or authorized designate. A signature in this area certifies that the information provided in the form and any supporting documentation required is accurate and true. **NOTE: the form will be returned where the original signature is missing.**

Date:
This is the date the form was completed and certified and signed by the licensee/FCC Provider or authorized designate. It is to be entered in YYYY/MM/DD format, e.g., where the date is September 28, 2018, the information must be entered as 2018/09/28.

Replacement Staff (please print)
The printed name of the caregiver identified as the Replacement Staff. Every effort should be made to ensure the name is legible. **NOTE: the form will be returned where the name is missing from this field.**

Signature:
This is the signature of the caregiver identified as the Replacement Staff. A signature in this area certifies that the information provided in the form and any supporting documentation required is accurate and true. **NOTE: the form will be returned where the original signature is missing.**

Date:
This is the date the form was completed, certified, and signed by the individual identified as Funded Staff Person. It is to be entered in YYYY/MM/DD format, e.g., where the date is September 28, 2018, the information must be entered as 2018/09/28.

For Office Use:
No information should be entered into this field. This space is for office use only.