Public Service Alliance of Canada
FAMILY CARE POLICY

OBJECTIVE

The PSAC fully recognizes that Family is not solely defined as consisting of "mother AND father with children" and may take several forms including, but not limited to: single parents, same-sex parents, dependant relatives residing in the household.

The objective of this policy is to remove one of the barriers which prevent members from participating fully in Union activities.

The Family Care Policy (FCP) is intended to assist the member in covering additional costs incurred as a direct result of attending an authorized PSAC activity.

Where the member is the sole caregiver at the time of the authorized union activity, the FCP will cover costs for care during the day outside normal work/school/daycare hours.

To achieve a maximum amount of flexibility, every effort will be made to provide on-site child care where Early Childhood Educated (ECE) or certified caregivers are available for hire. When on-site childcare is provided, caregivers will be made available for evening sessions that form part of the schedule of events.

WHAT IS NOT COVERED

Family care costs that **would have ordinarily been incurred during work hours** had the member been at his/her place of work.

The FCP shall not cover cost for care provided by a spouse/partner or a relative residing in the household.

WHO IS COVERED

Members are entitled to claim expenses related to the care of the following family members who reside on a full or part-time basis with the member:

1. A child under 18 years of age;
2. A person with a disability;
3. An adult, who is a dependant, requiring care.

COSTS COMPENSATED

Family care expenses will be reimbursed as follows:

1. Where the care is provided by someone *other than a licensed agency/caregiver or the spouse/partner*:

a) the **actual amount** up to a maximum of $50 per day[1] for the first family member;
b) the **actual amount** up to a maximum of $25 per day for each *additional* family member;
c) the **actual amount** up to a maximum of $30 per night[2], per family member for *overnight care*.

2. If care is provided by a licensed agency/attendant, the **actual cost** will be reimbursed.

3. Where child care is provided **on-site**, the cost of meals for the duration of the care and increased *shared* accommodation costs will be covered.

4. Other pre-approved *reasonable* expenses.

5. Upon request, consideration will be given to special needs or unusual circumstances resulting in costs which exceed the above rates and expenses allowable. Detailed information must be provided ***in advance for pre-approval.***

HOW TO CLAIM

A *completed* Family Care Expense Claim form must be submitted, accompanied by a **receipt which includes the caregiver's name, address, telephone number, license number (if applicable) and signature, as well as the dates and hours worked.**

INCOMPLETE FORMS WILL NOT BE PROCESSED FOR PAYMENT.

[1] Day is defined as care provided some time between the hours of 7:30 a.m. and 5:30 p.m.
[2] Night is defined as care provided some time between the hours of 5:31 p.m. and 7:29 a.m.

PSAC FAMILY CARE EXPENSE CLAIM FORM

COMPLETE ALL SECTIONS TO ENSURE PAYMENT OF CLAIM.

NAME OF MEMBER: ______________________________

ADDRESS: ______________________________

______________________________ **POSTAL CODE** ______________

PSAC FUNCTION: ______________________________
(TITLE OF CONFERENCE, COURSE, MEETING, ETC. - PLEASE SPECIFY)

DATE OF FUNCTION: ______________________________

CLAIMS WILL BE PROCESSED FOR EXPENSES INCURRED OUTSIDE NORMAL WORKING HOURS ONLY

-----THE FOLLOWING INFORMATION IS FOR PSAC INTERNAL USE ONLY AND WILL REMAIN CONFIDENTIAL-----

CARE PROVIDED BY: ☐ UNLICENSED CAREGIVER ☐ LICENSED AGENCY/CAREGIVER LICENSE NO: ______________

NAME OF CAREGIVER OR AGENCY : ______________________________

ADDRESS: ______________ ______________________________ __ PHONE:______________

DATE AND HOURS CARE WAS PROVIDED: ______________________________

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SECTION A - COST OF CARE

RATES:

UNLICENSED CARE
MAXIMUM $50/DAY FOR FIRST FAMILY MEMBER AND $25/DAY FOR EACH ADDTIONAL FAMILY MEMBER
MAXIMUM $30 /OVERNIGHT FOR EACH FAMILY MEMBER

LICENSED CARE
AS BILLED

FAMILY MEMBER & RELATION	*AGE(S)*			
1. ______________	________	____ DAY (S) @ ______ + _____ NIGHT(S) @ _____ $	________$
2. ______________	________	____ DAY (S) @ ______ + _____ NIGHT(S) @ _____ $	________$
3. ______________	________	____ DAY (S) @ ______ + _____ NIGHT(S) @ _____ $	________$

TOTAL A _ ________$

SECTION B - ADDITIONAL COSTS (SEE 4 UNDER COSTS COMPENSATED ON REVERSE)

1. ______________________________ __________$
2. ______________________________ __________$
3. ______________________________ __________$

ATTACH SUPPORTING DOCUMENTS. **TOTAL B ________ $**

PRE-APPROVED BY: ______________________ **SIGNATURE:** ______________________

SECTION C - SPECIAL CIRCUMSTANCES AS PRE-APPROVED (SEE 5 UNDER COSTS COMPENSATED)

COST AS APPROVED **(ATTACH DETAILED INFORMATION AND SUPPORTING DOCUMENTS)** **TOTAL C _______ _$**

TOTAL CLAIM (TOTAL A +TOTAL B + TOTAL C) __________

$

PLEASE ATTACH DETAILED RECEIPTS

I CERTIFY THAT THE ABOVE CLAIMED EXPENSES WERE INCURRED AS A DIRECT RESULT OF ATTENDING AN AUTHORIZED PSAC ACTIVITY.
SIGNATURE OF MEMBER ______________________ **RECOMMENDED FOR PAYMENT** ______________________

APPROVED FOR PAYMENT ______________________________ DATE: ______________________________