Direct Funding Receipt Form

Care Recipient Name:	Substitute Decision Maker (if applicable):
Recipient Address:	Care Manager (if designated)

Date	Description of Service (e.g. meal prep)	Cost of Service

TOTAL $ 0.00

Service Provider, please confirm (if not providing separate receipts):

- ☐ I have provided services and received payment as outlined above.

Signature of Service Provider _____ Date _____

Care Recipient or SDM/Care Manager (if applicable/designated), please confirm:

- ☐ I have paid for the above services.
- ☐ I have attached receipts indicating the services have been paid in full.

Signature of Care Recipient of SDM/Care Manager (if applicable/designated) _____ Date _____

Return this form along with all supporting documentation to the address listed below:

Nova Scotia Health, Home First/IADL Clerk, Continuing Care,
404 Charlotte St. Suite 200 (2nd floor), Sydney, NS B1P 1E2
HomeFirstIADLClerk@nshealth.ca
1-800-225-7225