NortheastArc
Adult Family Care

AFC Alternative Caregiver Reimbursement Form

Directions: ***Each form should include dates for 1 month only.**
***Make sure form is filled out completely.**
***REIMBURSEMENT FORMS MUST BE RETURNED TO THE AFC OFFICE BY THE 5TH OF THE MONTH**

Make check payable to AFC Alternative Caregiver (please print clearly):

Name: _____

Address: _____
Street Town State Zip

Dates of Service: From: _____ To: _____
month/day month/day

Mass Health AFC Member (please print name): _____
Member's level (1 or 2): _____

Days worked during the month:

TOTAL AMOUNT: $_____
*To calculate amount, multiply the number of days worked in the month by the members level rate.

Alternative Caregiver Signature: _____ Date: _____

Caregiver Signature: _____ Date: _____

OFFICE USE ONLY: Date Received: _____ Amount Paid: $_____
AFC Program Director (or designee) Verification:
_____
Date submitted to Administration and Finance: _____ Charge to: 570-46810 for FY24