

DEPENDENT FAMILY

ATTACH DEPENDENT CARE RECEIPTS

Upon satisfying the following criteria, State Council representatives or seated alternates shall be eligible for reimbursement of actual expenditures for hardship child, adults with special needs and/or elder care services of 80% of the California State minimum wage, not to exceed \$500.00 per dependent, per State Council meeting as per Standing Rule 1-7.

1. The member must be:
 - a. a duly elected representative or seated alternate to State Council in attendance at State Council; or
 - b. liaison in attendance at State Council; or
 - c. service center chair in attendance at State Council; or a
 - d. duly authorized member attending State Council on official business.
2. The member must submit verifiable documentation of proof of expenditure.
3. The child for which dependent care services reimbursement is requested must be:
 - a. a legal dependent of the member, and
 - b. under 16 years of age.
4. Dependent care service reimbursement would also include coverage for:
 - a. adults with special needs,
 - b. elder care.
5. Member must submit documentation that s/he is the primary caregiver for the dependent under this section.
6. Alignment to federal mandates – The recommended test must meet federal assessments enumerated in ESSA Title 1, Part A and the Individuals with Disabilities Education Act.

After each State Council meeting, the reimbursement forms with the accompanying documentation should be mailed to:

Governance Support Department
California Teachers Association
1705 Murchison Drive
Burlingame CA 94010

**MEMBER REIMBURSEMENT REQUEST FOR DEPENDENT FAMILY
CARE SERVICE EXPENSES AT STATE COUNCIL MEETINGS**



**ATTACH DEPENDENT
CARE RECEIPTS**

MEETING DATE: _____

NAME: _____
(PLEASE PRINT)

ADDRESS: _____
STREET CITY ZIP

DATE (Month/Day)	Friday /	Saturday /	Sunday /	TOTAL
HOURS				
AMOUNT	\$	\$	\$	\$

(CTA will reimburse actual expenditure for hardship child, adults with special needs and/or elder care services of 80% of the California State minimum wage, not to exceed \$500 per dependent, per State Council meeting)

List names and ages of dependent children and/or dependent person for whom care was required.

DEPENDENT'S NAME

AGE (Children only)

MEMBER SIGNATURE: _____

DATE: _____

GOVERNANCE APPROVAL: _____

DATE APPROVED: _____

White Copy – To Governance Support Dept., Burlingame

Yellow Copy – Retain For Your Records