BCTF Kids Matter Teachers Care

DEPENDANT CARE INVOICE

Bill to:

Member name _____ _____
Last name *First name*

Provider/Caregiver name _____ _____
Last name *First name*

Address _____ City _____ Postal Code _____

Phone_____ E-mail _____

Related to BCTF member or person receiving care (check one)	☐ Yes*	☐ No

*You selected 'Yes' to being related to a BCTF member or person receiving care; please specify your relationship.

Please specify: _____

Date(s) of service	Type of service provided (*e.g. elder care, childcare*)	Hours of care	x	Rate ($/hr)	=	Amount charged
Example: April 30, 2026	Elder care	8am – 11:15am = 3.25hrs 4pm - 6pm = 2hrs Total = *5.25hrs	x	$20	=	$105
			x		=	$
			x		=	$
					Total amount	$

☐ I hereby confirm that the above-referenced invoice has been paid by the BCTF member identified above.

Provider/Caregiver signature: _____ Date _____