PARALYZED VETERANS OF AMERICA - WI CHAPTER'S

FINANCIAL REQUEST FORM

DATE _____/_____/_____

NAME _____

ADDRESS _____

TELEPHONE # (_____)_____ _____ **EMAIL** _____

NAME AND ADDRESS OF EVENT _____

DATE OF EVENT _____**ARRIVAL DATE** _____**DEPARTURE DATE**_____

ESTIMATED TOTAL AMOUNT OF REIMBURSEMENT REQUEST $_____

MAXIMUM REQUEST AMOUNT FOR FULL MEMBERS: $1,500
MAXIMUM REQUEST AMOUNT FOR ASSOCIATE MEMBERS: $500

BREAKDOWN "ESTIMATE"

AIR FARE $_____ **MEALS** $ _____ **OTHER (SPEC.)** $_____
MILEAGE_____ **LODGING** $_____ **EQUIPMENT** $ _____

MUST SUBMIT EXPENSE REPORT AND CORRESPONDING RECEIPTS FOR EACH BREAKDOWN ESTIMATE

PERSONAL CARE ATTENDENT (PCA) INFORMATION (MANDATORY)

NAME:_____

ADDRESS:_____CITY_____STATE_____ZIP_____

TELEPHONE NUMBER: (_____) _____--_____ **VA APPROVED CAREGIVER** _____YES_____NO

PLEDGE & RELEASE OF LIABILITY

I have read and hereby agree to the terms of the PVA-WI's Sports & Travel Policies and Procedures. I understand if I do not complete the requirements, I may not be eligible for future financial assistance from the PVA Wisconsin Chapter until I have complied with the requirements.

If I am receiving additional funding from another source for this event, I am disclosing this information:

Amount: _____ Source: _____

SIGNATURE _____ **DATE** _____/_____/_____

APPROVING SIGNATURE _____ **DATE** _____/_____/_____

REVISED 10/29/2024

OFFICE USE ONLY

NOVICE _____
MEMBER/ASSOC MEM. _____
NOTIFIED
$$ APPROVED _____