

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
WITHIN 30 DAYS AFTER THE EVENT****

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	_____