Care Assistance Reimbursement Request

TO:	Mary Westfall, Treasurer
FROM:	
DATE:	

Please accept my request for reimbursement for care assistance based on the following information:

Name of Person with PD:		
Date	Time From To	Care Provider

◯ I have attached receipts for services provided for the dates indicated.
Reimbursement will not exceed $600 per family per calendar year.

◯ I certify that I am a current member of the Parkinson's Support Group of Green Valley.

Mail to: Parkinson's Support Group
PO Box 714
Green Valley, AZ 85622

_____
Signature

_____
Street Address

_____
City State Zip Code

Revised 4/2025