

**Home Education Program  
Funding Reimbursement Form  
SCHOOL ACT, SECTION 23(8)**

**Medicine Hat Catholic Separate Regional Division No. 20**  
1251 – 1<sup>st</sup>. Avenue S.W. Medicine Hat, AB T1A 8B4  
Telephone (403) 527-2292 Fax (403) 529-0917

Date of Receipt (attached)	Details of Expenditure	Amount Claimed
		\$
	Total Funding Claimed	\$

Student's Name: \_\_\_\_\_

Grade: \_\_\_\_\_

Parent's Name: \_\_\_\_\_

Parent's Address: \_\_\_\_\_  
Street, Apt. No.

\_\_\_\_\_

City, Province, Postal Code

\_\_\_\_\_

Telephone

Parent's Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Principal's Approval: \_\_\_\_\_

Date: \_\_\_\_\_

<u>FUNDING RECONCILIATION</u>	<u>EXPENDITURE CODE</u>
Money Available \$ _____	
Less: Funding Claimed to Date _____	
Amount of this Claim _____	
Alberta Distance Learning Centre _____	
Balance of Money Available \$ _____	