UNDE FAMILY CARE POLICY
(revised January 2025)

Objective

The UNDE fully recognizes that family is not solely defined as consisting of "mother and father with children" and may take several forms including, but not limited to: single parents, same-sex parents, dependent relatives residing in the household.

The objective of this policy is to remove one of the barriers which prevent members from participating in union activities.

The Family Care Policy (FCP) is intended to assist the member in covering additional fees incurred as a direct result of attending an authorized PSAC activity.

To achieve a maximum amount of flexibility, every effort will be made to provide on-site child care where Early Childhood Educated (ECE) or certified caregivers are available for hire. When on-site childcare is provided, caregivers will be made available for evening sessions that form part of the schedule of events.

Eligibility

Where the member is the sole caregiver at the time of the authorized union activity, the FCP will cover costs for care during the day **outside** normal work/school/daycare hours. Family care costs that **would have ordinarily been incurred during work hours** had the member been at his/her place of work **are not covered.**

The FCP shall not cover cost for care provided by a spouse/partner, former spouse/partner with custody rights or a relative residing in the household.

Members are entitled to claim fees related to the care of the following family members who reside on a full or part-time basis with the member:

1. A child under 18 years of age;
2. A person with a disability;
3. An adult, who is a dependant, requiring care.

How to Claim

A *completed* Family Care Expense Claim form must be submitted, **accompanied by a receipt*, which must include the following information:**

- Caregiver's full name
- Caregiver's full address
- Caregiver's telephone number
- Caregiver's license number (if applicable)
- Detailed dates and hours when the care was provided for each individual family member
- Amount charged
- Caregiver's signature

Reimbursement of Fees

1. Where the care is provided by someone other than a licensed agency/caregiver or the spouse/partner, former spouse/partner with custody rights:

a. the actual amount up to a maximum of $25 per hour, up to a maximum rate of $250 for each 24-hour period for a family of one dependent.

b. the actual amount up to a maximum of $50 per hour for, up to a maximum rate of $250 for each 24-hour period for a family of two dependents.

c. the actual amount up to a maximum of $50 per hour up to a maximum rate of $500 for each 24-hour period for a family of three dependents.

d. the actual amount up to a maximum of $50 per hour for a family of three depend-ents, and up to an additional $25 per hour for each additional dependent up to a maximum rate of $500 for each 24-hour period.

A "24 hour period" is defined as care provided between the hours of 7:30 a.m. to 7:29 a.m. the following day.

2. If care is provided by a licensed agency/ attendant, the **actual fees** will be reimbursed.

3. Where an on-site child care program is provided at the UNDE activity:

   a. increased shared accommodations costs will be covered;
   b. and where a dinner does not form part of the program, an allowance of $25 per child, per day may be reimbursed. *(Reimbursement will be based on participant's approved travel schedule)*

Pre-Approved Exceptions

Upon request, consideration will be given to special needs or unusual circumstances resulting in costs which exceed the above rates and expenses allowable**. Detailed information must be provided *in advance for pre-approval.***

UNDE Family Care Expense Claim Form

Complete all sections to ensure payment of claim.

The following information is for UNDE use only and will remain confidential.

MEMBER INFORMATION			
LAST NAME	FIRST NAME	PSAC MEMBERSHIP NUMBER	
STREET ADDRESS		CITY	PROVINCE
POSTAL CODE	TELEPHONE NUMBER	ACTIVITY DATE	
UNDE ACTIVITY (TITLE OF CONFERENCE, COURSE, MEETING, ETC. – PLEASE SPECIFY)			

CAREGIVER INFORMATION	
CARE PROVIDED BY ☐ UNLICENSED AGENCY/CAREGIVER ☐ LICENSED AGENCY/CAREGIVER	LICENSE NUMBER
CAREGIVER/AGENCY NAME	
MAILING ADDRESS	TELEPHONE NUMBER

SECTION A – FEES INCURRED (SEE COST COMPENSATED, SECTIONS 1 & 2 FOR APPLICABLE RATES)

FAMILY MEMBER & RELATION	AGE	DATE(S)	HOURS OF CARE	FEES PAID
1.				
2.				
3.				
4.				
			TOTAL COST (SECTION A)	

If additional space is required, use separate sheet and attach to this claim.

SECTION B – PRE-APPROVED EXCEPTIONS		
SPECIFY		
	TOTAL COST (SECTION B)	
x		
PRE-APPROVED BY		DATE

Attach all supporting documents and receipts.

☐ I certify that the above claimed expenses were incurred as a direct result of attending an authorized **PSAC** activity.

x	
MEMBER SIGNATURE	DATE

SECTION C – APPROVAL (UNDE INTERNAL USE ONLY)		
EXPLANATORY NOTES	TOTAL CLAIM (SECTIONS A + B)	
	RECOMMENDED FOR PAYMENT	
x		
APPROVED FOR PAYMENT BY		DATE