

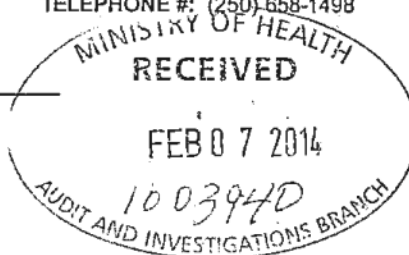
**MINISTRY OF HEALTH SERVICES
AUDIT AND INSPECTION COMMITTEE CLAIM FORM**

NAME: Mr. Endre Dolhai

TELEPHONE #: (250) 658-1498

MEETING DATE:

Jan. 30, 2014



FEES: Rate: \$300.00 per day x 2 (incl. prep.)

\$ 600.00v

TRAVEL REIMBURSEMENT CLAIM: (vehicle travel rate effective Mar 29/09)

Vehicle Travel: 20 # of KM x \$ 0.50 = 10.40v

\$ 10.40v

Ferry Costs: (Attach Receipts)

\$ _____

Air Travel: (Attach Receipts)

\$ _____

Misc: (highway toll charges, parking, taxi, car rental)

Itemize and attach receipts

\$ 6.00v

ACCOMMODATION:

Hotel/Non-Commercial Lodging _____ nights X \$ _____ per night

\$ _____

MEAL ALLOWANCE: (meal allowance rate effective Mar 29/09)

Breakfast	_____	X \$22.00	\$ _____
Lunch	_____	X \$22.00	\$ _____
Dinner	_____	X \$28.50	\$ _____
Breakfast & Lunch	_____	X \$30.00	\$ _____
Breakfast & Dinner	_____	X \$36.50	\$ _____
Lunch & Dinner	_____	X \$36.50	\$ _____
Breakfast, Lunch & Dinner	_____	X \$49.00	\$ _____

If no meal is claimed, you may claim \$14.00 for incidentals.

\$ _____

TOTAL CLAIM \$ 616.40v

PLEASE MAKE CHEQUE PAYABLE TO:

NAME: E. Dolhai

ADDRESS: s.22

CITY/PROVINCE/PC:

Signature: _____

RETURN CLAIM FORM TO:

Billing Integrity Program
5-2 1515 Blanshard St
Victoria BC V8W 3C8
Telephone: (250) 952-1864

STOB 5501 \$ 600.00 STOB 5515 \$ 16.40

PLEASE PAY GST

TO ACCOUNTS: FEB 17 2014

INVOICE (DIRECT OR MATCHED)		
Receipt # <u>410799</u>	Supplier # s.22	Location (Site) # 001
PO Number <u>66925JY0910008</u>		Total \$ Amount of Invoice <u>\$616.40</u>
Invoice # <u>FEB-07-2014</u>	Responsibility # 66925	Service Line 44225
STOB 55	Project # 6600000	Requisition # 5125
Line 1 \$ Amount <u>\$600.00</u>	Line 2 \$ Amount <u>\$16.40</u>	PO # or Cont # —

S. Montain

QR Signature

Certified that the work has been performed, goods received or conditions met.

Stephanie Montain

QR Print

QR Print

M. Hethcote
06/14/14

Updated April 2006

Page 1 of 35 HTH-2019-97770

PLACE FACE UP ON DASH

Expiration Date/Time

04:08 PM
JAN 30, 2014

Purchase Date/Time: 01:08pm Jan 30, 2014

Total Due: \$6.00

Rate: Park 3 Hours \$6.00

Total Paid: \$6.00

Payment Type: Card

Ticket #: 00000445

S/N #: 100008120002

Setting: Lot 057 - 1

Mach Name: Lot 57 -1

Card s.22

Auth #: 005955

**MINISTRY OF HEALTH
AUDIT AND INSPECTION COMMITTEE CLAIM FORM**

NAME: **Mr. Endre Dolhai** TELEPHONE #: **(250) 658-1498**

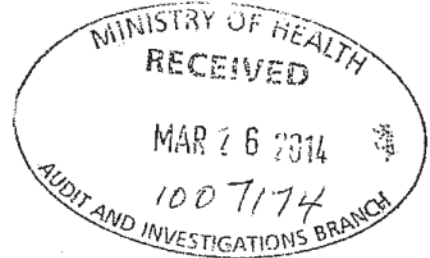
MEETING DATE: **MARCH 21, 2014**

FEES: Rate: \$300.00 Per Day X **2** (number of Days) = **Incl. Prep.**

Total Fees: \$ **600.00** (A)

TRAVEL REIMBURSEMENT CLAIM: (travel rates effective Apr 1/10)

Vehicle Travel: **20** KM @ \$0.50 = \$ **10.00** (a)
 Ferry Costs: (Attach Receipts less HST) = \$ _____ (b)
 Air Travel: (Attach Receipts less HST) = \$ _____ (c)
 Misc: (highway toll charges, parking, taxi, car rental)
 Itemize and attach receipts (less HST) = \$ **6.00** (d)



ACCOMODATION:

Hotel/Non-Commercial Lodging _____ nights X \$ _____ /night = \$ _____ (e)

MEAL ALLOWANCE:

Breakfast _____ X \$22.00 = \$ _____ (f)
 Lunch _____ X \$22.00 = \$ _____ (g)
 Dinner _____ X \$28.50 = \$ _____ (h)
 Breakfast & Lunch _____ X \$30.00 = \$ _____ (i)
 Breakfast & Dinner _____ X \$36.50 = \$ _____ (j)
 Lunch & Dinner _____ X \$36.50 = \$ _____ (k)
 Breakfast, Lunch & Dinner _____ X \$49.00 = \$ _____ (l)
 If no meal is claimed, you may claim \$14.00 for incidentals. = \$ _____ (m)

Total Travel Expenses (sum a thru m): \$ **16.40** (B)

HST = \$ _____ (C)

Claimant Signature: _____

Claim Total (sum A+B+C): \$ **616.40**

PLEASE MAKE CHEQUE PAYABLE TO:

NAME: **Mr. Endre Dolhai**
 ADDRESS: **S.22**

RETURN CLAIM FORM TO: **Billing Integrity Program
 5-2 1515 Blanshard St
 Victoria BC V8W 3C8**

Telephone: **S.22**

INVOICE (DIRECT OR MATCHED)		
Receipt # 47444	Supplier # S.22	Location (Site) # 001
PO Number 66925LOE11001		Total \$ Amount of Invoice \$616.40
Invoice # MAR-26-2014 \$616.40	Responsibility # 66925	Service Line 44225
STOB 55	Project # 6600000	Requisition # 5125
Line 1 Amount \$600.00	Line 2 Amount \$16.40	PO# or Cont #

STOB 5501 \$ **600.00** 5515 \$ **16.40**

QR(print and sign):

EA (print):

To: Accounts: **APR 01 2014**

Stephanie Monteiro
M. St. 15/15/14
MAR 31/14 (Apr 11)

PLACE FACE UP ON DASH

Expiration Date/Time

04:19 PM
MAR 21, 2014

Purchase Date/Time: 01:19pm Mar 21, 2014
Total Due: \$6.00 Rate: Park 3 Hours \$6.00
Total Paid: \$6.00 Payment Type: Card
Ticket #: 00004977
S/N #: 100008120002
Setting: Lot 057 - 1
Mach Name: Lot 57 -1

Card **S.22**

Auth #: 025003

**MINISTRY OF HEALTH
AUDIT AND INSPECTION COMMITTEE CLAIM FORM**

NAME: **Mr. Endre Dolhai** TELEPHONE #: **(250) 658-1498**

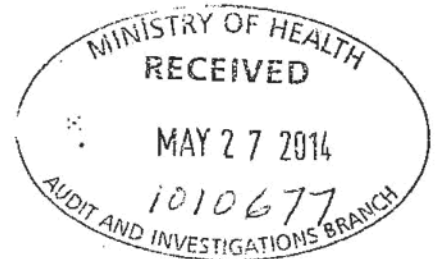
MEETING DATE: May 21/14

FEEs: Rate: \$300.00 Per Day X 2 (number of Days) = (Incl. Prep.)

Total Fees: \$ 600.00 (A)

TRAVEL REIMBURSEMENT CLAIM: (travel rates effective Apr 1/10)

Vehicle Travel: 20 KM @ \$0.50 = \$ 10.00 (a)
 Ferry Costs: (Attach Receipts less HST) = \$ _____ (b)
 Air Travel: (Attach Receipts less HST) = \$ _____ (c)
 Misc: (highway toll charges, parking, taxi, car rental)
 Itemize and attach receipts (less HST) = \$ 7.50 (d)



ACCOMMODATION:

Hotel/Non-Commercial Lodging _____ nights X \$ _____ /night = \$ _____ (e)

MEAL ALLOWANCE:

Breakfast _____ X \$22.00 = \$ _____ (f)
 Lunch _____ X \$22.00 = \$ _____ (g)
 Dinner _____ X \$28.50 = \$ _____ (h)
 Breakfast & Lunch _____ X \$30.00 = \$ _____ (i)
 Breakfast & Dinner _____ X \$36.50 = \$ _____ (j)
 Lunch & Dinner _____ X \$36.50 = \$ _____ (k)
 Breakfast, Lunch & Dinner _____ X \$49.00 = \$ _____ (l)
 If no meal is claimed, you may claim \$14.00 for incidentals. = \$ _____ (m)

Total Travel Expenses (sum a thru m): \$ 17.90 (B)

HST = \$ _____ (C)

Claimant Signature: _____

Claim Total (sum A+B+C): \$ 617.90

PLEASE MAKE CHEQUE PAYABLE TO:

NAME: Mr. Endre Dolhai
 ADDRESS: S.22

RETURN CLAIM FORM TO: Billing Integrity Program
 5-2 1515 Blanshard St
 Victoria BC V8W 3C8

Telephone: S.22

INVOICE (DIRECT OR MATCHED)		
Receipt # <u>47866</u>	Supplier # <u>S.22</u>	Location (Site) # <u>001</u>
PO Number <u>66925LOE11001</u>		Total \$ Amount of Invoice <u>\$617.50</u>
Invoice # <u>27-MAY-2014 \$617.50</u>	Responsibility # <u>66925</u>	Service Line <u>44225</u>
STOB <u>55</u>	Project # <u>6600000</u>	Requisition # <u>5125</u>
Line 1 Amount <u>\$600.00</u>	Line 2 Amount <u>\$17.50</u>	PO# or Cont # _____

STOB 5501 \$ 600.00 5515 \$ 17.50

QR(print and sign): Chantelle Jones

EA (print): [Signature] JUN 4/14

(Apr 11)

To: Accounts: JUN 05 2014

PLACE FACE UP ON DASH

Expiration Date/Time

04:16 PM
MAY 21, 2014

Purchase Date/Time: 01:16pm May 21, 2014
Total Due: \$7.50 Rate: Park 3 Hours \$7.50
Total Paid: \$7.50 Payment Type: Card
Ticket #: 00001054
S/N #: 100008120002
Setting: Lot 057 - 1
Mach Name: Lot 57 -1

Card s.22

Auth #: 015715

KING RECEIPT PARKING RECEIPT

Ministry of Health – AIC Member Claim Form

FEES, MEALS AND MILEAGE

Meeting Date	DISTANCE TRAVELLED	B	Meals L	D	Number of Sessions	Session Rate	Fees Claimed
July 15/14	20				2 (prep) incl	300.00	670.00
Total Kms	20					Total	670.00

LODGING, AIRFARE, PARKING, TAXI, OTHER TRAVEL EXPENSES (receipts required)

DATE	DESCRIPTION	AMOUNT
7/15/14	Parking	7.50
	Mileage 20 Kms x \$0.50	10.40
Section Total		7.50

OFFICE USE ONLY:

Total Sessions: @ =

Breakfast : @ =

Lunch : @ =

Dinner : @ =

Total KM : 20 @ .50 = 10.40

Additional Expenses: =

INVOICE (DIRECT OR MATCHED)

48249 s.22

Receipt # Supplier/Site

66925LOE11001 \$1600.00 \$17.90

PO # \$6001 \$6002

23-7-11-2014 161025 44225

Invoice # \$6001 Resp SL

PLEASE REMOVE HST-TAX CODE

Project # Req #

161025 5125

CONTRACTOR DETAILS

Purpose of travel: AIC MEETING DATE:

Claimant: Mr. Endre Dolhai

Address: S.22

Telephone

Email:

Signature

Return Claim Form (with original receipts)

Billing Integrity Program
5-2 1515 Blanshard St
Victoria BC V8W 3C8
(250) 952-2732 Fax (250) 952-2605
Email: HLTH.BIP@gov.bc.ca

Signature & Printed Name
Certified that the work has been performed, goods received or conditions met

Ea Print

PLACE FACE UP ON DASH

Expiration Date/Time

04:20 PM
JUL 15, 2014

Purchase Date/Time: 01:20pm Jul 15, 2014
Total Due: \$7.50 Rate: Park 3 Hours \$7.50
Total Paid: \$7.50 Payment Type: Cash
Ticket #: 00005529
S/N #: 100008120002
Setting: Lot 057 - 1
Mach Name: Lot 57 -1

Card s.22

Auth #: 025078

**MINISTRY OF HEALTH
AUDIT AND INSPECTION COMMITTEE CLAIM FORM**

NAME: **Mr. Endre Dolhai**

TELEPHONE #: **(250) 658-1498**

MEETING DATE: OCT 8/14

FEEs: Rate: \$300.00 Per Day X 2 (number of Days) = (Bul Prep)

Total Fees: \$ 600.00 (A)

TRAVEL REIMBURSEMENT CLAIM: (travel rates effective Apr 1/10)

Vehicle Travel: 20 KM @ \$0.50 = \$ 10.40 (a)

Ferry Costs: (Attach Receipts less HST) = \$ _____ (b)

Air Travel: (Attach Receipts less HST) = \$ _____ (c)

Misc: (highway toll charges, parking, taxi, car rental)
Itemize and attach receipts (less HST) = \$ 7.50 (d)

ACCOMMODATION:

Hotel/Non-Commercial Lodging _____ nights X \$ _____ /night = \$ _____ (e)

MEAL ALLOWANCE:

Breakfast _____ X \$22.00 = \$ _____ (f)

Lunch _____ X \$22.00 = \$ _____ (g)

Dinner _____ X \$28.50 = \$ _____ (h)

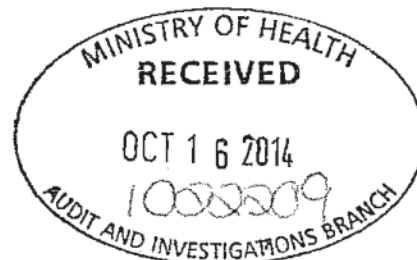
Breakfast & Lunch _____ X \$30.00 = \$ _____ (i)

Breakfast & Dinner _____ X \$36.50 = \$ _____ (j)

Lunch & Dinner _____ X \$36.50 = \$ _____ (k)

Breakfast, Lunch & Dinner _____ X \$49.00 = \$ _____ (l)

If no meal is claimed, you may claim \$14.00 for incidentals. = \$ _____ (m)



Total Travel Expenses (sum a thru m): \$ 17.90 (B)

HST = \$ _____ (C)

Claimant Signature: _____

Claim Total (sum A+B+C): \$ 617.90

PLEASE MAKE CHEQUE PAYABLE TO:

NAME: Mr. Endre Dolhai
ADDRESS: S.22

RETURN CLAIM FORM TO: Billing Integrity Program
5-2 1515 Blanshard St
Victoria BC V8W 3C8

Telephone: S.22

INVOICE (DIRECT OR MATCHED)		
Receipt # <u>48944</u>	Supplier # <u>S.22</u>	Location (Site) # <u>001</u>
PO Number <u>66925LOE11001</u>		Total \$ Amount of Invoice <u>\$1617.90</u>
Invoice # <u>16-OCT-2014 \$617.90</u>	Responsibility # <u>66925</u>	Service Line <u>44225</u>
STOB <u>55</u>	Project # <u>6600000</u>	Requisition # <u>5125</u>
Line 1 Amount <u>\$600.00</u>	Line 2 Amount <u>\$17.90</u>	PO# or Cont #

STOB 5501 \$ 600.00 5515 \$ 17.90

To: Accounts: _____

QR (print and sign):

EA (print):

OCT 16 2014

Processed by: Stephanie Monteiro (Apr 11)

PLACE FACE UP ON DASH

Expiration Date/Time

04:15 PM
OCT 08, 2014

Purchase Date/Time: 01:15pm Oct 08, 2014
Total Due: \$7.50 Rate: Park 3 Hours \$7.5
Total Paid: \$7.50 Payment Type: Card
Ticket #: 00013493
S/N #: 100008120002
Setting: Lot 057 - 1
Mach Name: Lot 57 -1

Card S.22

Auth #: 089500

INVOICE RECEIPT PARKING RECEIPT

COMM **EE MEMBER CLAIM FORM**
Billing Integrity Program

Name: ENDRE DOLHAI

Description of Services:

☒ Audit and Inspection Committee Meeting

☐ Other: _____

Rate of Pay: \$ 300 ☐ Session (3.5 hours)

FEES

Date: Jan. 22, 2015 \$ _____
Number of Sessions: 2 x Rate \$ 600.00
Incl. Prep. TOTAL FEES: _____

EXPENSES

Include receipts for any of the categories claimed under Travel and Accommodation. Do not include GST in totals.

Travel

To: Ministry of H. From: Home
Vehicle Travel: 20 kilometers x \$0.52 \$ 10.40
Ferry Costs: \$ _____
Parking: \$ 7.50
Air Travel: \$ _____
Miscellaneous: \$ _____

Accommodation

Hotel/Non-commercial Lodging \$ _____

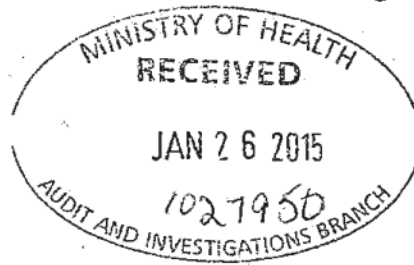
Meal Allowance

Breakfast Only (\$22.00/day) \$ _____
Lunch Only (\$22.00/day) \$ _____
Dinner Only (\$28.50/day) \$ _____
Breakfast and Lunch Only (\$30.00/day) \$ _____
Breakfast and Dinner Only (\$36.50/day) \$ _____
Lunch and Dinner Only (\$36.50/day) \$ _____
Full Day (\$49.00 a day) \$ _____

TOTAL EXPENSES: \$ 17.90

TOTAL FEES AND EXPENSES: \$ 617.90

Jan. 22, 2015



RETURN CLAIM FORM TO:
CONTRACT ADMINISTRATION
BILLING INTEGRITY PROGRAM
MINISTRY OF HEALTH
FINANCE AND CORPORATE SERVICES DIVISION
PO BOX 9647 STN PROV GOVT
VICTORIA BC V8W 9P4

FAX NUMBER: 250-952-2605
PHONE NUMBER: 250-952-2732

OFFICE USE ONLY

INVOICE NO. <u>26-JAN-2015 \$ 617.90</u>			
RECEIPT NO. <u>49829</u>	SUPPLIER NO. <u>s.22</u>	SITE NO. <u>001</u>	
PURCHASE ORDER NO. <u>66925 LOE11001</u>		REQ. NO. <u>5125</u>	
RESP. NO. <u>66925</u>	SERV. LINE <u>44225</u>	STOB <u>6001/6002</u>	PROJECT NO. <u>6600000</u>
6001 AMOUNT <u>\$600.00</u>	6002 AMOUNT <u>\$17.90</u>	TOTAL AMOUNT <u>\$ 617.90</u>	

x Chantelle Jones
Quality Receiver Signature

Chantelle Jones
Quality Receiver (Print Name)

Date of Signature: Jan 27/15

M. Skelton
Expense Authority Signature

M. Skelton
Expense Authority (Print Name)

Date of Signature: Jan 28/15

Processed By: Stephanie Monteiro

Date Sent to Accounts: JAN 29 2015

PLACE FACE UP ON DASH

Expiration Date/Time

04:14 PM
JAN 22, 2015

Purchase Date/Time: 01:14pm Jan 22, 2015
Total Due: \$7.50 Rate: Park 3 Hours \$7.5
Total Paid: \$7.50 Payment Type: Card
Ticket #: 00022580
S/N #: 100008120002
Setting: Lot 057 - 1
Mach Name: Lot 57 -1

Card S.22

Auth #: 032433

PARKING RECEIPT
PARKING REC

COMMITTEE MEMBER CLAIM FORM
Billing Integrity Program



Name: Endre Dolhai

Description of Services:

☒ Audit and Inspection Committee Meeting

☐ Other: _____

Rate of Pay: \$ 300.00 ² Session (3.5 hours)
Ind. Pap.

FEES

Date: Mar. 26/15 \$ 600.00 ✓
Number of Sessions: 2 x Rate \$ _____

TOTAL FEES:

EXPENSES

Include receipts for any of the categories claimed under Travel and Accommodation. Do not include GST in totals.

Travel MIP
To: Home From: Home

Vehicle Travel: 20 kilometers x \$0.52 \$ 10.40 ✓
Ferry Costs: \$ _____
Parking: \$ _____
Air Travel: \$ _____
Miscellaneous: \$ _____

Accommodation

Hotel/Non-commercial Lodging \$ _____

Meal Allowance

Breakfast Only (\$22.00/day) \$ _____
Lunch Only (\$22.00/day) \$ _____
Dinner Only (\$28.50/day) \$ _____
Breakfast and Lunch Only (\$30.00/day) \$ _____
Breakfast and Dinner Only (\$36.50/day) \$ _____
Lunch and Dinner Only (\$36.50/day) \$ _____
Full Day (\$49.00 a day) \$ _____

TOTAL EXPENSES: \$ 10.40 ✓

TOTAL FEES AND EXPENSES: \$ 610.40 ✓

RETURN CLAIM FORM TO:
CONTRACT ADMINISTRATION
BILLING INTEGRITY PROGRAM
MINISTRY OF HEALTH
FINANCE AND CORPORATE SERVICES DIVISION
PO BOX 9647 STN PROV GOVT
VICTORIA BC V8W 9P4

FAX NUMBER: 250-952-2605
PHONE NUMBER: 250-952-2732

OFFICE USE ONLY

INVOICE NO. <u>26-MAR-2015 \$610.40</u>			
RECEIPT NO. <u>501663</u>	SUPPLIER NO. <u>s.22</u>	SITE NO. <u>001</u>	
PURCHASE ORDER NO. <u>6692510E11001</u>		REQ. NO. <u>5125</u>	
RESP. NO. <u>66925</u>	SERV. LINE <u>44225</u>	STOB <u>5501/5515</u>	PROJECT NO. <u>6600000</u>
6001 AMOUNT <u>\$600.00</u>	6002 AMOUNT <u>\$10.40</u>	TOTAL AMOUNT <u>\$610.40</u>	

C. Jones
Quality Receiver Signature

Montale Jones
Quality Receiver (Print Name)

Date of Signature: May 26/15

[Signature]
Expense Authority Signature

M. S. [Signature]
Expense Authority (Print Name)

Date of Signature: Mar 31/15

Processed By: Stephanie Monteiro

Date Sent to Accounts: _____

COMMITTEE MEMBER CLAIM FORM
Billing Integrity Program



Name: ENDRE DOLHAI

Description of Services:

☒ Audit and Inspection Committee Meeting

☐ Other: _____

Rate of Pay: \$ 300 ☐ Session (3.5 hours)

FEES

Date: May 22, 2015

Number of Sessions: 2 x Rate
(Incl. Prep.)

TOTAL FEES:

EXPENSES

Include receipts for any of the categories claimed under Travel and Accommodation. Do not include GST in totals.

Travel

To: Meeting From: Home

Vehicle Travel: 20 kilometers x \$0.52

Ferry Costs:

Parking:

Air Travel:

Miscellaneous:

Accommodation

Hotel/Non-commercial Lodging

Meal Allowance

Breakfast Only (\$22.00/day)

Lunch Only (\$22.00/day)

Dinner Only (\$28.50/day)

Breakfast and Lunch Only (\$30.00/day)

Breakfast and Dinner Only (\$36.50/day)

Lunch and Dinner Only (\$36.50/day)

Full Day (\$49.00 a day)

TOTAL EXPENSES:

TOTAL FEES AND EXPENSES:



RETURN CLAIM FORM TO:

CONTRACT ADMINISTRATION
BILLING INTEGRITY PROGRAM
MINISTRY OF HEALTH
FINANCE AND CORPORATE SERVICES DIVISION
PO BOX 9647 STN PROV GOVT
VICTORIA BC V8W 9P4

FAX NUMBER: 250-952-2805

PHONE NUMBER: 250-952-2732

OFFICE USE ONLY

INVOICE NO. <u>27-MAY-2015 \$67.90</u>			
RECEIPT NO. <u>51221</u>	SUPPLIER NO. <u>s.22</u>	SITE NO. <u>001</u>	
PURCHASE ORDER NO. <u>66925 LOE11001</u>		REQ. NO. <u>5125</u>	
RESP. NO. <u>66925</u>	SERV. LINE <u>44225</u>	STOB <u>5501/5515</u>	PROJECT NO. <u>6600000</u>
6001 AMOUNT <u>\$600.00</u>	6002 AMOUNT <u>\$7.90</u>	TOTAL AMOUNT <u>\$67.90</u>	

Quality Receiver Signature

Chantelle Jones
Quality Receiver (Print Name)

Date of Signature: May 28, 2015

Expense Authority Signature

M. Salim
Expense Authority (Print Name)

Date of Signature: Jun 5/15

Processed By: Stephanie Monteiro

Date Sent to Accounts: JUN 09 2015

PLACE FACE UP ON DASH

Expiration Date/Time

04:14 PM
MAY 22, 2015

Purchase Date/Time: 01:14pm May 22, 2015
Total Due: \$7.50 Rate: Park 3 Hours \$7.5
Total Paid: \$7.50 Payment Type: Card
Ticket #: 00032730
S/N #: 100008120002
Setting: Lot 057 - 1
Mach Name: Lot 57 -1

Card S.22

Auth #: 058374

COMMITTEE MEMBER CLAIM FORM



Name: ENDRE DOLTAI

Description of Services:

☒ Audit and Inspection Committee Meeting

☐ Other: _____

Rate of Pay: \$ 300⁰⁰ ☐ Session (3.5 hours)

FEES

Date: July 31/15 \$ 600⁰⁰
 Number of Sessions: 2 x Rate \$ 1200⁰⁰
Incl. Prep. TOTAL FEES:

EXPENSES

Include receipts for any of the categories claimed under Travel and Accommodation. Do not include GST in totals.

Travel Kinisky
 To: Home From: Home
 Vehicle Travel: 20 kilometers x \$0.52 \$ 10.40 ✓
 Ferry Costs: \$ 3.81
 Parking: \$ 4.00
 Air Travel: \$ _____
 Miscellaneous: \$ _____

Accommodation

Hotel/Non-commercial Lodging \$ _____

Meal Allowance

Breakfast Only (\$22.00/day) \$ _____
 Lunch Only (\$22.00/day) \$ _____
 Dinner Only (\$28.50/day) \$ _____
 Breakfast and Lunch Only (\$30.00/day) \$ _____
 Breakfast and Dinner Only (\$36.50/day) \$ _____
 Lunch and Dinner Only (\$36.50/day) \$ _____
 Full Day (\$49.00 a day) \$ _____

TOTAL EXPENSES: \$ 4.00

TOTAL FEES AND EXPENSES: \$ 614.40

RETURN CLAIM FORM TO:
 CONTRACT ADMINISTRATION
 BILLING INTEGRITY PROGRAM
 MINISTRY OF HEALTH
 FINANCE AND CORPORATE SERVICES DIVISION
 PO BOX 9647 STN PROV GOVT
 VICTORIA BC V8W 9P4

FAX NUMBER: 250-952-2605
 PHONE NUMBER: 250-952-2732

OFFICE USE ONLY

INVOICE NO. <u>06-AUG-2015 \$614.21</u>			
RECEIPT NO. <u>51866</u>	SUPPLIER NO. <u>s.22</u>	SITE NO. <u>001</u>	
PURCHASE ORDER NO. <u>66925 LOE11001</u>		REQ. NO. <u>5135</u>	
RESP. NO. <u>66925</u>	SERV. LINE <u>44225</u>	STOB <u>5501/5515</u>	PROJECT NO. <u>6600000</u>
6001 AMOUNT <u>\$600.00</u>	6002 AMOUNT <u>\$14.21</u>	TOTAL AMOUNT <u>\$614.21</u>	

x Chantelle Jones
 Quality Receiver Signature

Chantelle Jones
 Quality Receiver (Print Name)

Date of Signature: Aug 14/15

20.21
 Expense Authority Signature

DAVID FAIRBANKS
 Expense Authority (Print Name)

Date of Signature: AUG 17 2015

Processed By: Stephanie Monteiro

Date Sent to Accounts: _____



City Of Victoria
View St. Parkade
THANK YOU

RECEIPT M1

ENTRY TIME:
31.07.15 13:12
EXIT TIME:
31.07.15 16:23
PARK-DUR.: HRS:MIN
0:03:11
AMOUNT:
\$ 4.00

KIND OF PAYMENT:
s.22

201
AUTH. CODE 039409
REF. 71

GST No. 12206394
GST INCLUDED \$0.19



MEDICAL SERVICES COMMISSION

MINUTE OF THE COMMISSION

Page 1 of 1

Appointment of Beneficiary Representative of the Audit and Inspection Committee

15-075

Effective September 5, 2015, Endre Dolhai is reappointed for a three-year term as a member of the Audit and Inspection Committee representing beneficiaries.

Tom Vincent
Chair
Medical Services Commission

Dated this

21st

day of

August

A.D. 20

15



Name: ENDLE DOLHAI

Description of Services:

☒ Audit and Inspection Committee Meeting

☐ Other: _____

Rate of Pay: \$ 300.00 ☐ Session (3.5 hours)

FEES

Date: Nov. 19/15 \$ _____

Number of Sessions: 2 x Rate \$ 600.00
Incl. Prep. TOTAL FEES: 600.00 ✓

EXPENSES

Include receipts for any of the categories claimed under Travel and Accommodation. **Do not include GST in totals.**

Travel

To: Home From: Ming H.

Vehicle Travel: 20 kilometers x \$0.52 \$ 10.40 ✓

Ferry Costs: \$ _____

Parking: \$ 3.50 ✓

Air Travel: \$ _____

Miscellaneous: \$ _____

Accommodation

Hotel/Non-commercial Lodging \$ _____

Meal Allowance

Breakfast Only (\$22.00/day) \$ _____

Lunch Only (\$22.00/day) \$ _____

Dinner Only (\$28.50/day) \$ _____

Breakfast and Lunch Only (\$30.00/day) \$ _____

Breakfast and Dinner Only (\$36.50/day) \$ _____

Lunch and Dinner Only (\$36.50/day) \$ _____

Full Day (\$49.00 a day) \$ _____

TOTAL EXPENSES: \$ 13.90 ✓

TOTAL FEES AND EXPENSES: \$ 613.90 ✓

RETURN CLAIM FORM TO:
CONTRACT ADMINISTRATION
BILLING INTEGRITY PROGRAM
MINISTRY OF HEALTH
FINANCE AND CORPORATE SERVICES DIVISION
PO BOX 9647 STN PROV GOVT
VICTORIA BC V8W 9P4

FAX NUMBER: 250-952-2605
PHONE NUMBER: 250-952-2732

OFFICE USE ONLY PLEASE PAY GST

INVOICE NO. <u>25-NOV-2015 8613.90</u>		
RECEIPT NO. <u>52736</u>	SUPPLIER NO. <u>s.22</u>	SITE NO. <u>001</u>
PURCHASE ORDER NO. <u>66925 LOE11001</u>		REQ. NO. <u>5125</u>
RESP. NO. <u>66925</u>	SERV. LINE <u>44225</u>	STOB <u>5501/5515</u>
PROJECT NO. <u>6600000</u>		
6001 AMOUNT <u>\$600.00</u>	6002 AMOUNT <u>\$13.90</u>	TOTAL AMOUNT <u>\$613.90</u>

x Chantelle Jones
Quality Receiver Signature

Chantelle Jones
Quality Receiver (Print Name)

Date of Signature: DEC 3/15

Expense Authority Signature

Michelle A.
Expense Authority (Print Name)

Date of Signature: Dec 3/15

Processed By: Stephanie Monteiro

Date Sent to Accounts: DEC 04 2015





City Of Victoria
Bastion Parkade
THANKYOU

RECEIPT M3

ENTRY TIME:
19.11.15 13:02
EXIT TIME:
19.11.15 15:58
PARK-DUR.: HRS:MIN
0:02:56
AMOUNT:
\$ 3.50

KIND OF PAYMENT:

s.22

201
AUTH. CODE 027842
REF. 13

GST No. 12206394
GST INCLUDED

Name: ENDRE DOLMAI

Description of Services:

☒ Audit and Inspection Committee Meeting☐ Other: _____Rate of Pay: \$ 300.00 ☐ Session (3.5 hours)

FEES

Date: May 26, 2016Number of Sessions: 2 x Rate
(Incl. Trp.)TOTAL FEES: 600.00

EXPENSES

Include receipts for any of the categories claimed under Travel and Accommodation.

Travel

To: Meeting From: HomeVehicle Travel: 20 kilometers x \$0.53 \$ 10.60 ✓

Ferry Costs: \$ _____

Parking: \$ _____

Air Travel: \$ _____

Miscellaneous: \$ _____

Accommodation

Hotel/Non-commercial Lodging \$ _____

Meal Allowance

Breakfast Only (\$22.00/day) \$ _____

Lunch Only (\$22.00/day) \$ _____

Dinner Only (\$28.50/day) \$ _____

Breakfast and Lunch Only (\$30.00/day) \$ _____

Breakfast and Dinner Only (\$36.50/day) \$ _____

Lunch and Dinner Only (\$36.50/day) \$ _____

Full Day (\$49.00 a day) \$ _____

TOTAL EXPENSES: \$ 10.60 ✓TOTAL FEES AND EXPENSES: \$ 610.60 ✓

RETURN CLAIM FORM TO:

CONTRACT ADMINISTRATION
BILLING INTEGRITY PROGRAM
MINISTRY OF HEALTH
FINANCE AND CORPORATE SERVICES DIVISION
PO BOX 9647 STN PROV GOVT
VICTORIA BC V8W 9P4

FAX NUMBER: 250-952-2605

PHONE NUMBER: 250-952-2732

OFFICE USE ONLY

INVOICE NO. <u>30-MAY-2016 \$610.60</u>			
RECEIPT NO. <u>5A120</u>	SUPPLIER NO. <u>s.22</u>	SITE NO. <u>001</u>	
PURCHASE ORDER NO. <u>66925 LOE11001</u>		REQ. NO. <u>5125</u>	
RESP. NO. <u>66925</u>	SERV. LINE <u>44225</u>	STOB <u>5501/5515</u>	PROJECT NO. <u>6600000</u>
5501 AMOUNT <u>\$600.00</u>	5515 AMOUNT <u>\$10.60</u>	TOTAL AMOUNT <u>\$610.60</u>	

PLEASE PAY GST

x Chantelle Jones
Quality Receiver SignatureChantelle Jones
Quality Receiver (Print Name)Date of Signature: May 30/16

Expense Authority Signature

M. Hillson
Expense Authority (Print Name)Date of Signature: May 30/16Processed By: Stephanie MonteiroDate Sent to Accounts: JUN 01 2016

COMMITTEE MEMBER CLAIM FORM
Billing Integrity Program

Name: ENDLE DOLMAI

Description of Services:

☒ Audit and Inspection Committee Meeting

☐ Other: _____

Rate of Pay: \$ 300.00 ☐ Session (3.5 hours)

FEES

Date: Aug. 16/16 \$ _____

Number of Sessions: 2 x Rate \$ 600.00
(Incl. Prep.) TOTAL FEES: 600.00

EXPENSES

Include receipts for any of the categories claimed under Travel and Accommodation.

Travel

To: Meeting From: Home
Vehicle Travel: 20 kilometers x \$0.53 \$ 10.60
Ferry Costs: \$ _____
Parking: \$ 3.00
Air Travel: \$ _____
Miscellaneous: \$ _____

Accommodation

Hotel/Non-commercial Lodging \$ _____

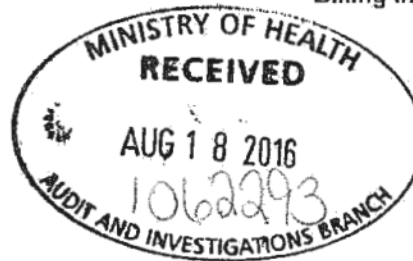
Meal Allowance

Breakfast Only (\$22.00/day) \$ _____
Lunch Only (\$22.00/day) \$ _____
Dinner Only (\$28.50/day) \$ _____
Breakfast and Lunch Only (\$30.00/day) \$ _____
Breakfast and Dinner Only (\$36.50/day) \$ _____
Lunch and Dinner Only (\$36.50/day) \$ _____
Full Day (\$49.00 a day) \$ _____

TOTAL EXPENSES: \$ 13.60

TOTAL FEES AND EXPENSES: \$ 613.60

KIND OF PAYMENT: CASH
GST No. 12206394
GST INCLUDED
AMOUNT: \$ 3.00
ENTRY TIME: 16.08.16 13:15
EXIT TIME: 16.08.16 15:58
PARK-DUR.: 0:02:43 HRS:MIN
RECEIPT M1
City of Victoria
View St. Parkade
THANK YOU



RETURN CLAIM FORM TO:
CONTRACT ADMINISTRATION
BILLING INTEGRITY PROGRAM
MINISTRY OF HEALTH
FINANCE AND CORPORATE SERVICES DIVISION
PO BOX 9647 STN PROV GOVT
VICTORIA BC V8W 9P4

FAX NUMBER: 250-952-2605
PHONE NUMBER: 250-952-2732

OFFICE USE ONLY

INVOICE NO. <u>18-AUG-2016</u>			
RECEIPT NO. <u>54723</u>	s.22	SITE NO. <u>001</u>	
PURCHASE ORDER NO. <u>66925 / LOE 11001</u>		REQ. NO. <u>5185</u>	
RESP. NO. <u>66925</u>	SERV. LINE <u>44225</u>	STOB <u>5501/5515</u>	PROJECT NO. <u>6600000</u>
5501 AMOUNT \$ <u>600.00</u>	5515 AMOUNT \$ <u>13.60</u>	TOTAL AMOUNT \$ <u>613.60</u>	
PLEASE PAY GST			

Chantelle Jones
Quality Receiver Signature

Chantelle Jones
Quality Receiver (Print Name)

Date of Signature: Aug 18/16

Evan Machin
Expense Authority Signature

Evan Machin
Expense Authority (Print Name)

Date of Signature: 29 Aug 16

Processed By: Vanessa Karrel

Date Sent to Accounts: _____





Memorandum

Ministry of Health
Billing Integrity Program

1069349

File: 925-20/AIC/DOLH

To: Marie Thelisma

**Re: Increase to Audit and Inspection Committee Member Purchase Order –
Endre Dolhai, Public Representative**

Background

The Audit and Inspection Committee (AIC) members are appointed by the Medical Services Commission and are paid in accordance with other board/committee members that are appointed.

The amount paid for fees per meeting is calculated according to Treasury Board Directives. The expenses are based on Group Two employee amounts. The total annual payment of fees and expenses is determined by the program area, based on the number of meetings, etc.

The Purchased Order (PO) amount can be increased if additional funds are required to pay invoices.

For Decision

As of October 2016, the remaining PO commitment balance for Endre Dolhai is \$1,900.00 for fees, and \$1,571.68 for expenses.

The AIC members meet approximately every 1.5 - 2 months. Mr. Dolhai charges on average \$600.00 for fees, and \$20.00 for expenses.

Mr. Dolhai's appointment term ends on September 4, 2018. Accordingly, there are two years or approximately 17 AIC meetings prior to September 4, 2018.

To accommodate for the upcoming AIC meetings to occur prior to September 4, 2018, it is recommended that the PO commitment for Mr. Dolhai is increased by \$9,500.00 for fees.

Sincerely,

Vanessa Karrel
Contract Administrator
Billing Integrity Program

COMMITTEE MEMBER CLAIM FORM
Billing Integrity Program



Name: ENDLE DOLMAI - Vice-Chair

Description of Services:

☒ Audit and Inspection Committee Meeting Oct. 20/2016
☒ Other: Meeting with Chair and Sr. Staff to discuss staffing on Oct 4/16

Rate of Pay: \$ 300.00 ☐ Session (3.5 hours)

FEES - other at \$100/hr. 1.5 hr. 127.50
150.00

Date: October 20/16

Number of Sessions: 2 x Rate
(Incl. Prep.)

TOTAL FEES: 727.50

EXPENSES

Include receipts for any of the categories claimed under Travel and Accommodation.

Travel

To: Meeting From: Home

Vehicle Travel: 40 kilometers x \$0.53

Ferry Costs:

Parking:

Air Travel:

Miscellaneous:

Accommodation

Hotel/Non-commercial Lodging

Meal Allowance

Breakfast Only (\$22.00/day)

Lunch Only (\$22.00/day)

Dinner Only (\$28.50/day)

Breakfast and Lunch Only (\$30.00/day)

Breakfast and Dinner Only (\$36.50/day)

Lunch and Dinner Only (\$36.50/day)

Full Day (\$49.00 a day)

TOTAL EXPENSES: \$ 24.20

TOTAL FEES AND EXPENSES: \$ 771.20

RETURN CLAIM FORM TO:
CONTRACT ADMINISTRATION
BILLING INTEGRITY PROGRAM
MINISTRY OF HEALTH
FINANCE AND CORPORATE SERVICES DIVISION
PO BOX 9647 STN PROV GOVT
VICTORIA BC V8W 9P4

FAX NUMBER: 250-952-2605
PHONE NUMBER: 250-952-2732

OFFICE USE ONLY

INVOICE NO. <u>20-OCT-2016</u>		748.70	
RECEIPT NO. <u>55272</u>	S.22	SUPPLIER NO.	SITE NO. <u>001</u>
PURCHASE ORDER NO. <u>66925 / LOE11001</u>		REQ. NO. <u>5125</u>	
RESP. NO. <u>66925</u>	SERV. LINE <u>44225</u>	STOB <u>5501/5515</u>	PROJECT NO. <u>6600000</u>
5501 AMOUNT <u>\$750.00</u>	5515 AMOUNT <u>\$21.20</u>	TOTAL AMOUNT <u>\$771.20</u>	

PLEASE PAY GST 748.70

Quality Receiver Signature

Vanessa Karrel

Quality Receiver (Print Name)

Date of Signature: Oct 20/16

EM

Expense Authority Signature

Evan Mackin

Expense Authority (Print Name)

Date of Signature: 20 Oct 16

Processed By: Vanessa Karrel

Date Sent to Accounts: NOV 30 2016



[Signature]

COMMITTEE MEMBER CLAIM FORM
Billing Integrity Program



Name: ENDRE DOLHAI

Description of Services:

☒ Audit and Inspection Committee Meeting

☐ Other: _____

Rate of Pay: \$ 300 ☐ Session (3.5 hours)

FEES

Date: Jan. 31, 2017

Number of Sessions: 2 x Rate

(Including Prep.)

TOTAL FEES:

\$ 600.00

EXPENSES

Include receipts for any of the categories claimed under Travel and Accommodation.

Travel

To: Meeting From: Home

Vehicle Travel: 20 kilometers x \$0.53 ✓ \$ 10.60

Ferry Costs: \$ _____

Parking: ✓ \$ 4.50

Air Travel: \$ _____

Miscellaneous: \$ _____

Accommodation

Hotel/Non-commercial Lodging \$ _____

Meal Allowance

Breakfast Only (\$22.00/day) \$ _____

Lunch Only (\$22.00/day) \$ _____

Dinner Only (\$28.50/day) \$ _____

Breakfast and Lunch Only (\$30.00/day) \$ _____

Breakfast and Dinner Only (\$36.50/day) \$ _____

Lunch and Dinner Only (\$36.50/day) \$ _____

Full Day (\$49.00 a day) \$ _____

TOTAL EXPENSES: ✓ \$ 15.10

TOTAL FEES AND EXPENSES: ✓ \$ 615.10

RETURN CLAIM FORM TO:
CONTRACT ADMINISTRATION
BILLING INTEGRITY PROGRAM
MINISTRY OF HEALTH
FINANCE AND CORPORATE SERVICES DIVISION
PO BOX 9647 STN PROV GOVT
VICTORIA BC V8W 9P4

FAX NUMBER: 250-952-2605
PHONE NUMBER: 250-952-2732

OFFICE USE ONLY

INVOICE NO. <u>21 MAR 2017 \$ 615.10</u>		
RECEIPT NO. <u>56085</u>	QUOTED REP NO. <u>\$22</u>	SITE NO. <u>001</u>
PURCHASE ORDER NO. <u>66925 LOE11001</u>		REQ NO. <u>5125</u>
RESP. NO. <u>66925</u>	SERV. LINE <u>44225</u>	STOB <u>5501/5515</u>
PROJECT NO. <u>6600000</u>		
5501 AMOUNT <u>\$ 600.00</u>	5515 AMOUNT <u>\$ 15.10</u>	TOTAL AMOUNT <u>\$ 615.10</u>

PLEASE PAY GST

Vanessa Karrel
Quality Receiver Signature

Vanessa Karrel
Quality Receiver (Print Name)

Date of Signature: Mar 21/17

Evan Machin
Expense Authority Signature

Evan Machin
Expense Authority (Print Name)

Date of Signature: 21 March 17

Processed By: Vanessa Karrel

Date Sent to Accounts: _____

4336
IS YOUR PARKING SPACE
1645 Douglas
▼ PARKING TIME EXPIRES AT ▼
31/01/
02:47pm



CITY OF
VICTORIA

ENJOY DOWNTOWN

2017 Ticket 0111241
AMOUNT CAD 004.50 CC
GST Paid: CAD 000.21
31/01/2017 1:17pm

Name: ENDLE DOLHAI

Description of Services:

☒ Audit and Inspection Committee Meeting

☐ Other: _____

Rate of Pay: \$ 300.00 ☐ Session (3.5 hours)

FEES

Date: MARCH 21, 2017 \$ _____
Number of Sessions: 2 x Rate \$ 600.00
(Ind. Prep.) TOTAL FEES: _____

EXPENSES

Include receipts for any of the categories claimed under Travel and Accommodation.

Travel

To: Meeting From: Home
Vehicle Travel: 20 kilometers x \$0.53 \$ 10.60
Ferry Costs: \$ _____
Parking: \$ _____
Air Travel: \$ _____
Miscellaneous: \$ _____

Accommodation

Hotel/Non-commercial Lodging \$ _____

Meal Allowance

Breakfast Only (\$22.00/day) \$ _____
Lunch Only (\$22.00/day) \$ _____
Dinner Only (\$28.50/day) \$ _____
Breakfast and Lunch Only (\$30.00/day) \$ _____
Breakfast and Dinner Only (\$36.50/day) \$ _____
Lunch and Dinner Only (\$36.50/day) \$ _____
Full Day (\$49.00 a day) \$ _____

TOTAL EXPENSES: \$ 10.60

TOTAL FEES AND EXPENSES: \$ 610.60

COMMITTEE MEMBER CLAIM FORM

MINISTRY OF HEALTH
RECEIVED

MAR 22 2017

1082120
AUDIT AND INVESTIGATIONS BRANCH



RETURN CLAIM FORM TO:
CONTRACT ADMINISTRATION
BILLING INTEGRITY PROGRAM
MINISTRY OF HEALTH
FINANCE AND CORPORATE SERVICES DIVISION
PO BOX 9647 STN PROV GOVT
VICTORIA BC V8W 9P4

FAX NUMBER: 250-952-2605
PHONE NUMBER: 250-952-2732

OFFICE USE ONLY

INVOICE NO. <u>22MAR2017 \$ 610.60</u>			
RECEIPT NO. <u>50082</u>	S.22	SITE NO. <u>001</u>	
PURCHASE ORDER NO. <u>66925/LOE11001</u>		REQ. NO. <u>5125</u>	
RESP. NO. <u>66925</u>	SERV. LINE <u>44225</u>	STOB <u>5501/5515</u>	PROJECT NO. <u>6600000</u>
5501 AMOUNT <u>\$ 600.00</u>	5515 AMOUNT <u>\$ 10.60</u>	TOTAL AMOUNT <u>\$ 610.60</u>	

PLEASE PAY GST

Quality Receiver Signature

Vanessa Karrel

Quality Receiver (Print Name)

Date of Signature: Mar 22/17

Evan Machin

Expense Authority Signature

EVAN MACHIN

Expense Authority (Print Name)

Date of Signature: 22 March 17

Processed By: Vanessa Karrel

Date Sent to Accounts: _____

Name: ENDRE DOLHAI

Description of Services:

☒ Audit and Inspection Committee Meeting

☐ Other: _____

Rate of Pay: \$ 300.00 ☐ Session (3.5 hours)

FEES

Date: MAY 16, 2017 \$ _____

Number of Sessions: 2 x Rate \$ 600.00

(Incl. Prep.)

TOTAL FEES:

EXPENSES

Include receipts for any of the categories claimed under Travel and Accommodation.

Travel

To: Meeting From: Home

Vehicle Travel: 20 kilometers x \$0.53 \$ 10.60

Ferry Costs: \$ _____

Parking: \$ 4.00

Air Travel: \$ _____

Miscellaneous: \$ _____

Accommodation

Hotel/Non-commercial Lodging \$ _____

Meal Allowance

Breakfast Only (\$22.00/day) \$ _____

Lunch Only (\$22.00/day) \$ _____

Dinner Only (\$28.50/day) \$ _____

Breakfast and Lunch Only (\$30.00/day) \$ _____

Breakfast and Dinner Only (\$36.50/day) \$ _____

Lunch and Dinner Only (\$36.50/day) \$ _____

Full Day (\$49.00 a day) \$ _____

TOTAL EXPENSES: \$ 14.60

TOTAL FEES AND EXPENSES: \$ 614.60



MEMBER CLAIM FORM
Billing Integrity Program



RETURN CLAIM FORM TO:
CONTRACT ADMINISTRATION
BILLING INTEGRITY PROGRAM
MINISTRY OF HEALTH
FINANCE AND CORPORATE SERVICES DIVISION
PO BOX 9647 STN PROV GOVT
VICTORIA BC V8W 9P4

FAX NUMBER: 250-952-2605
PHONE NUMBER: 250-952-2732

OFFICE USE ONLY

INVOICE NO. <u>19 MAY 2017 \$614.60</u>			
RECEIPT NO. <u>541692</u>	SUPPLIER NO. <u>s.22</u>	SITE NO. <u>001</u>	
PURCHASE ORDER NO. <u>66925/LOE 11/001</u>		REQ. NO. <u>5125</u>	
RESP. NO. <u>66925</u>	SERV. LINE <u>44225</u>	STOB <u>5501/5515</u>	PROJECT NO. <u>6600000</u>
5501 AMOUNT <u>\$600.00</u>	5515 AMOUNT <u>\$14.60</u>	TOTAL AMOUNT <u>\$614.60</u>	

PLEASE PAY GST

Quality Receiver Signature

Quality Receiver (Print Name)

Date of Signature:

Expense Authority Signature

Expense Authority (Print Name)

Date of Signature:

Processed By:

Date Sent to Accounts:

Sent by email on May 18/17



City Of Victoria
View St. Parkade
THANK YOU

RECEIPT M1

ENTRY TIME:
16.05.17 12:37
EXIT TIME:
16.05.17 15:43
PARK-DUR.: HRS:MIN
0:03:05
AMOUNT:
\$ 4.00

KIND OF PAYMENT:
s.22

201
AUTH. CODE 091423
REF. 13

GST No. 12206394
GST INCLUDED



COMMITTEE MEMBER CLAIM FORM
Billing Integrity Program



Name: ENDRE DOLHAI

Description of Services:

☒ Audit and Inspection Committee Meeting Sep. 13/17

☐ Other: _____

Rate of Pay: \$ 300 ☐ Session (3.5 hours)

FEES

Date: Sep. 17/17 \$ _____
Number of Sessions: 2 x Rate \$ 600.00
(Including Prep.) TOTAL FEES: \$ _____

EXPENSES

Include receipts for any of the categories claimed under Travel and Accommodation.

Travel

To: Meeting From: Home
Vehicle Travel: 20 kilometers x \$0.53 \$ 10.60
Ferry Costs: \$ _____
Parking: \$ 5.50
Air Travel: \$ _____
Miscellaneous: \$ _____

Accommodation

Hotel/Non-commercial Lodging \$ _____

Meal Allowance

Breakfast Only (\$22.00/day) \$ _____
Lunch Only (\$22.00/day) \$ _____
Dinner Only (\$28.50/day) \$ _____
Breakfast and Lunch Only (\$30.00/day) \$ _____
Breakfast and Dinner Only (\$36.50/day) \$ _____
Lunch and Dinner Only (\$36.50/day) \$ _____
Full Day (\$49.00 a day) \$ _____

TOTAL EXPENSES: \$ 16.10

TOTAL FEES AND EXPENSES: \$ 616.10

RETURN CLAIM FORM TO:
CONTRACT ADMINISTRATION
BILLING INTEGRITY PROGRAM
MINISTRY OF HEALTH
FINANCE AND CORPORATE SERVICES DIVISION
PO BOX 9647 STN PROV GOVT
VICTORIA BC V8W 9P4

FAX NUMBER: 250-952-2605
PHONE NUMBER: 250-952-2732

OFFICE USE ONLY

INVOICE NO. <u>19 SEPT 2017 \$616.10</u>		
RECEIPT NO. <u>57200</u>	DATE <u>S.22</u>	SITE NO. <u>001</u>
PURCHASE ORDER NO. <u>66925 / LOE11001</u>		REQ. NO. <u>5125</u>
RESP. NO. <u>66925</u>	SERV. LINE <u>44225</u>	STOB <u>5501/5515</u>
PROJECT NO. <u>6600000</u>		
5501 AMOUNT <u>\$600.00</u>	5515 AMOUNT <u>\$16.10</u>	TOTAL AMOUNT <u>\$616.10</u>

PLEASE PAY GST

Quality Receiver Signature

Quality Receiver (Print Name)

Date of Signature: Sep 19/17

Expense Authority Signature

Expense Authority (Print Name)

Date of Signature: 19 Sept 17

Processed By: Vanasse Starkey

SEP 19 2017

Date Sent to Accounts: _____

Name: ENDLE DOLHAI

Description of Services:

☒ Audit and Inspection Committee Meeting

☐ Other: _____

Rate of Pay: \$ 300 ☐ Session (3.5 hours)

FEES

Date: Dec. 12, 2017

Number of Sessions: 2 x Rate
(Ind. Prp.)

TOTAL FEES:

EXPENSES

Include receipts for any of the categories claimed under Travel and Accommodation.

Travel

To: Meeting From: Home

Vehicle Travel: 20 kilometers x \$0.53

Ferry Costs:

Parking:

Air Travel:

Miscellaneous:

Accommodation

Hotel/Non-commercial Lodging

Meal Allowance

Breakfast Only (\$22.00/day)

Lunch Only (\$22.00/day)

Dinner Only (\$28.50/day)

Breakfast and Lunch Only (\$30.00/day)

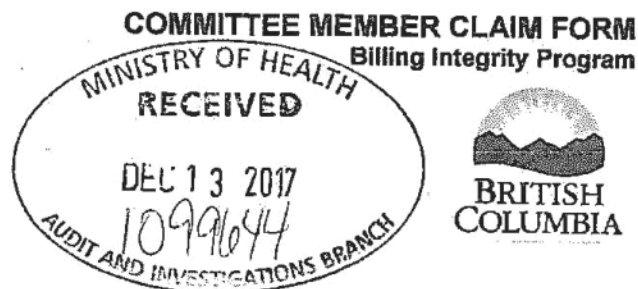
Breakfast and Dinner Only (\$36.50/day)

Lunch and Dinner Only (\$36.50/day)

Full Day (\$49.00 a day)

TOTAL EXPENSES:

TOTAL FEES AND EXPENSES:



RETURN CLAIM FORM TO:
CONTRACT ADMINISTRATION
BILLING INTEGRITY PROGRAM
MINISTRY OF HEALTH
FINANCE AND CORPORATE SERVICES DIVISION
PO BOX 9647 STN PROV GOVT
VICTORIA BC V8W 9P4

FAX NUMBER: 250-952-2605
PHONE NUMBER: 250-952-2732

OFFICE USE ONLY

INVOICE NO. 13DEC2017 \$610.60		
RECEIPT NO. 57788	S. 22	SITE NO. 001
PURCHASE ORDER NO. 66925 / LOE11001		REQ. NO. 5125
RESP. NO. 66925	SERV. LINE 44225	PROJECT NO. 5501/5515 6600000
5501 AMOUNT \$600	5515 AMOUNT \$10.60	TOTAL AMOUNT \$610.60

PLEASE PAY GST

Quality Receiver Signature

Vanessa Starkey

Quality Receiver (Print Name)

Date of Signature: Dec 13/17

Evan Machin

Expense Authority Signature

EVAN MACHIN

Expense Authority (Print Name)

Date of Signature: 13 Dec 17

Processed By: Vanessa Starkey

Date Sent to Accounts:

DEC 14 2017

COMMITTEE MEMBER CLAIM FORM



Name: Endre Dolhai

Description of Services:

☒ Audit and Inspection Committee Meeting

☐ Other: _____

Rate of Pay: \$ 300 ☐ Session (3.5 hours)

FEES

Date: Feb 7/18

Number of Sessions: 2 x Rate

TOTAL FEES:

EXPENSES

Include receipts for any of the categories claimed under Travel and Accommodation.

Travel

To: Mtg From: Home

Vehicle Travel: 20 kilometers x \$0.53

Ferry Costs:

Parking:

Air Travel:

Miscellaneous:

Accommodation

Hotel/Non-commercial Lodging

Meal Allowance

Breakfast Only (\$22.00/day)

Lunch Only (\$22.00/day)

Dinner Only (\$28.50/day)

Breakfast and Lunch Only (\$30.00/day)

Breakfast and Dinner Only (\$36.50/day)

Lunch and Dinner Only (\$36.50/day)

Full Day (\$49.00 a day)

TOTAL EXPENSES: \$ 13.60

TOTAL FEES AND EXPENSES: \$ 613.60

RETURN CLAIM FORM TO:

CONTRACT ADMINISTRATION
BILLING INTEGRITY PROGRAM
MINISTRY OF HEALTH
FINANCE AND CORPORATE SERVICES DIVISION
PO BOX 9647 STN PROV GOVT
VICTORIA BC V8W 9P4

FAX NUMBER: 250-952-2605

PHONE NUMBER: 250-952-2732

OFFICE USE ONLY

INVOICE NO. <u>8FEB2018</u>			
RECEIPT NO. <u>58136</u>	SUPPLIER NO. <u>s.22</u>	SITE NO. <u>001</u>	
PURCHASE ORDER NO. <u>66925 / LOE11001</u>		REQ. NO. <u>5125</u>	
RESP. NO. <u>66925</u>	SERV. LINE <u>44225</u>	STOB <u>5501/5515</u>	PROJECT NO. <u>6600000</u>
5501 AMOUNT \$ <u>600.00</u>	5515 AMOUNT \$ <u>13.60</u>	TOTAL AMOUNT \$ <u>613.60</u>	

PLEASE PAY GST

Quality Receiver Signature

Vanessa Starkey

Quality Receiver (Print Name)

Date of Signature: Feb 8/18

Evan Machin

Expense Authority Signature

Evan Machin

Expense Authority (Print Name)

Date of Signature: 8 Feb 18

Processed By: Vanessa Starkey

Date Sent to Accounts: FEB 08 2018

City of Victoria
Bastion Parkade

Receipt Number: H1031800123666
Ticket-Nr: 30107379
In: 02/07/2018 12:31
Out: 02/07/2018 15:09
Duration: 02:38

Transient Parker \$ 3.00

Total: \$ 3.00

Validations: \$ 0.00

Balance Due: \$ 3.00

Credit Card \$ 3.00

Change: \$ 0.00

GST No. 12206394
GST INCLUDED

COMMITTEE MEMBER CLAIM FORM
Billing Integrity Program



Name: ENDRE DOLHAI

Description of Services:

☒ Audit and Inspection Committee Meeting

☐ Other: _____

Rate of Pay: \$ 300 ☐ Session (3.5 hours)

FEES

Date: March 28, 2018

Number of Sessions: 2 x Rate

(Incl. Prep.)

TOTAL FEES:

\$ 600.00

EXPENSES

Include receipts for any of the categories claimed under Travel and Accommodation.

Travel

To: Meeting From: Home

Vehicle Travel: 20 kilometers x \$0.53 \$ 10.60

Ferry Costs: \$ _____

Parking: \$ _____

Air Travel: \$ _____

Miscellaneous: \$ _____

Accommodation

Hotel/Non-commercial Lodging \$ _____

Meal Allowance

Breakfast Only (\$22.00/day) \$ _____

Lunch Only (\$22.00/day) \$ _____

Dinner Only (\$28.50/day) \$ _____

Breakfast and Lunch Only (\$30.00/day) \$ _____

Breakfast and Dinner Only (\$36.50/day) \$ _____

Lunch and Dinner Only (\$36.50/day) \$ _____

Full Day (\$49.00 a day) \$ _____

TOTAL EXPENSES: \$ _____

TOTAL FEES AND EXPENSES: \$ 610.60

RETURN CLAIM FORM TO:
CONTRACT ADMINISTRATION
BILLING INTEGRITY PROGRAM
MINISTRY OF HEALTH
FINANCE AND CORPORATE SERVICES DIVISION
PO BOX 9647 STN PROV GOVT
VICTORIA BC V8W 9P4

FAX NUMBER: 250-952-2605
PHONE NUMBER: 250-952-2732

OFFICE USE ONLY

INVOICE NO. <u>29 MAR 2018</u>				SUPPLIER NO. <u>610.60</u>	
RECEIPT NO. <u>58549</u>		SITE NO. <u>001</u>		REQ. NO. <u>5125</u>	
PURCHASE ORDER NO. <u>66925/LOE11001</u>				PROJECT NO. <u>6600000</u>	
RESP. NO. <u>66925</u>	SERV. LINE <u>44225</u>	STOB <u>5501/5515</u>	TOTAL AMOUNT <u>\$610.60</u>		
5501 AMOUNT <u>\$600.00</u>		5515 AMOUNT <u>\$10.60</u>		TOTAL AMOUNT <u>\$610.60</u>	

PLEASE PAY GST

[Signature]
Quality Receiver Signature

Vanessa Starkey
Quality Receiver (Print Name)

Mar 29/18
Date of Signature:

[Signature]
Expense Authority Signature

Evan Machin
Expense Authority (Print Name)

29 March 18
Date of Signature:

Vanessa Starkey
Processed By:

MAR 29 2018
Date Sent to Accounts:

COMMITTEE MEMBER CLAIM FORM
Billing Integrity Program

Name: ENDRE DOLHAI

Description of Services:

☒ Audit and Inspection Committee Meeting

☒ Other: MPC Meeting

Rate of Pay: \$ 300 ☒ Session (3.5 hours)

FEES

Date: June 27/2018

Number of Sessions: 3 x Rate

TOTAL FEES:

\$ 900.00
\$ 900.00

EXPENSES

Include receipts for any of the categories claimed under Travel and Accommodation.

Travel

To: Meeting From: Home
Vehicle Travel: 20 kilometers x \$0.54

Ferry Costs:

Parking:

Air Travel:

Miscellaneous:

Accommodation

Hotel/Non-commercial Lodging

Meal Allowance

Breakfast Only (\$22.00/day)

Lunch Only (\$22.00/day)

Dinner Only (\$28.50/day)

Breakfast and Lunch Only (\$30.00/day)

Breakfast and Dinner Only (\$36.50/day)

Lunch and Dinner Only (\$36.50/day)

Full Day (\$49.00 a day)

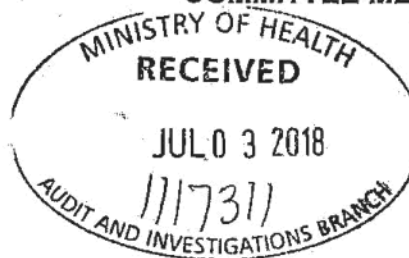
TOTAL EXPENSES:

TOTAL FEES AND EXPENSES:

\$ 10.80
\$ 15.25

\$ 216.05
\$ 25.05
\$ 26.05

\$ 926.05



RETURN CLAIM FORM TO:
CONTRACT ADMINISTRATION
BILLING INTEGRITY PROGRAM
MINISTRY OF HEALTH
FINANCE AND CORPORATE SERVICES DIVISION
PO BOX 9647 STN PROV GOVT
VICTORIA BC V8W 9P4

FAX NUMBER: 250-952-2605
PHONE NUMBER: 250-952-2732

OFFICE USE ONLY

INVOICE NO. 3 JUL 2018 \$ 926.05			
RECEIPT NO. 59050	SUPPLIER NO. s.22	SITE NO. 001	
PURCHASE ORDER NO. 66925/LOE11001		REQ. NO.	
RESP. NO. 66925	SERV. LINE 44225	STOB 5501/5515	PROJECT NO. 6600000
5501 AMOUNT \$ 900.00	5515 AMOUNT \$ 26.05	TOTAL AMOUNT \$ 926.05	

PLEASE PAY GET

Vanessa Starkey
Quality Receiver Signature
Vanessa Starkey
Quality Receiver (Print Name)
Date of Signature: July 3/18
E. Machin
Expense Authority Signature
Evan Machin
Expense Authority (Print Name)
Date of Signature: 3 July 18
Processed By: Vanessa Starkey
Date Sent to Accounts: JUL 03 2018