

**EXPENSE REPORT**

For the Month of: \_\_\_\_\_

Participant Name: \_\_\_\_\_ (Please Print)      Check Payable to: \_\_\_\_\_ (Please Print)

Date of Expense (MM/DD/YY)	Activity	Budget Category	Expense Amount
<b>Total:</b>			

I certify that the expenses listed above were provided in support of and approved by the Participant/Designee as noted by the signature below.

\_\_\_\_\_  
 Signature of person seeking expense reimbursement

\_\_\_\_\_  
 Date: (MM/DD/YY) (Required)

\_\_\_\_\_  
 Signature of Participant/Designee (Required)

\_\_\_\_\_  
 Date: (MM/DD/YY) (Required)

**PLEASE NOTE:**

1. Original ITEMIZED receipts MUST be attached.
2. Form MUST be submitted MONTHLY within 30 days following the expense.
3. W-9 required for all Community Classes and Contractors
4. Complete Bill and Proof of Payment required with each request

**Signing and submitting false information may lead to a charge of Medicaid fraud**

Remit to: P.O. Box 1320, Monticello, NY 12701