ISS INDEPENDENT SUPPORT SERVICES INC.
Make your Own Path

EXPENSE REPORT

For the Month of: _____

Participant Name: _____ Check Payable to: _____
(Please Print) (Please Print)

Date of Expense (MM/DD/YY)	**Activity**	**Budget Category**	**Expense Amount**

Total: 0

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

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Participant Name: _____ Check Payable to: _____
(Please Print) (Please Print)

Date of Expense (MM/DD/YY)	Activity	Budget Category	Expense Amount
		Total:	0

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

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Signature of person seeking expense reimbursement **Date: (MM/DD/YY) (Required)**

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Signature of Participant/Designee (Required) **Date: (MM/DD/YY) (Required)**

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