Reimbursement Form

Program:

Period Dates: _____ **to** _____

Payment to: _____

CDI Contact:

Participant:

Description of Expenses/Destination	Date	Total Miles		Amount		Totals
	Total Miles		*		>>>>>>>>>>	
					Total of Check	

Must be submitted within 90 days of service
No Payments made without receipts

Repayment of Items Returned or Sold (page 53 LAOM)
If an item is returned or sold, the money from that item must be returned to us so we can refund payer

!! Signing Verifies that Goods & Services Have Been Received !!
Signature of Participant/Managing Party Approving

If submitting mileage, I declare that I have a valid driver's license and current proof of insurance.

Signature of Person Claiming Expenses

Signature: _____ **Date:** _____

Signature : _____

Print Name: _____

Options for Submitting (Due Mondays)	
Fax: 1-888-400-3238 (toll free) **Text:** payroll@yourfse.com **Email:** payroll@yourfse.com	**Mail:** Consumer Directions P.O. Box 517 St. Joseph, MN 56374