Fiscal Intermediary Services for Self-Directed Supports

Expense Report

Month/Year: ____

Participants Name: ____

Check Payable to (include full name & address): ___________________________

____

Date of Expense	Activity	Goal #	Budget Category	Expense Amount
****Signing and submitting false information may lead to a charge of Medicaid fraud***			**TOTAL:**	

_________________________________ ______________

Signature of person seeking reimbursement **Date (mm/dd/yyyy)**

_________________________________ ______________

Signature of Participant/Designee (Required) **Date (mm/dd/yyyy)**

*****NOTE**

1. Original ITEMIZED receipts MUST be attached
2. TAX & TIP are NOT reimbursable.
3. Form must be completed monthly, on the 10th of the following service month expenses occurred.
4. W-9 required for ALL community classes & Contractors/Vendors.

Person Centered Care Services
150 Granite Ave.
Staten Island, NY 10303
718-370-1088