**INDIVIDUALISED FUNDING**

**CLIENT EXPENSE REIMBURSEMENT**

|  |  |  |
| --- | --- | --- |
| **CLIENT NAME: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_****CLIENT NUMBER: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |  |  |
| **FROM**: (Name of the person being paid) **\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_** |  | **TO:** |
|  |  | LIFEWISE Health and Disability |
|  |  | Fax 09 630 8956 |
|  |  | Email: timesheets@lifewise.org.nz  |

**Bank account name for reimbursement: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Bank account number for reimbursement: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

|  |  |  |
| --- | --- | --- |
| **EXPENSE** | **DATE** | **AMOUNT** |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
| **TOTAL**  |  |  |

**Note – copies of receipts must be attached in order for expense claims to be reimbursed**

I accept that I am fully responsible for the management of my Personal Budget.

I confirm, in relation to this claim for payment, that:

* the above information is a true and accurate record of the services/supports provided and or/expenses incurred
* I have complied with all of my Responsibilities in the Standard Agreement Declaration – Service Agreement
* all services/supports/expenses for which I have claimed payment have been incurred or accrued by me as at the date of this claim
* I have made, and will retain, full records supporting this claim. I will make these records available for audit on request.

**Signed:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_