



REQUEST FOR EXPENSE REIMBURSEMENT

Due by the 1st and the 16th of every month.
Use one form per client, event or reason.
Original Receipt required- image okay.

Employee Name (Print clearly): _____

Name of Client, Event or Reason: _____

Use one line per expense or trip.

Date of Expense	Item Type (Mileage, Parking, Supplies)	Detailed Description (Destination, Location, Specific Items)	Mileage/ Quantity	Cost
Mileage subtotal is multiplied by the IRS rate of .575 per mile. # of Miles ____ x .575 = ____				
Subtotals:			\$	\$
Total amount submitted for reimbursement (Mileage reimbursement amount plus other expense amount)			\$	

Sinai In-Home Care Expense Reimbursement Policy:

- **What we reimburse:** SHC reimburses for **mileage, parking and supply expenses** that have been previously authorized only by a supervisor or in a Service Plan. **Use one form per client, event or reason. Use one line per expense or trip. Send original receipt which is required. An image of the receipt is okay if submitted by email.**
- **When to submit request by:** Reimbursements must be submitted to the SHC office on a timely basis. For any expenses incurred between the 1st and 15th of the month, signed forms are due to the office before or by the end of the day on the **16th of the month**. For any expenses incurred between the 16th and the last day of the month, signed forms are due to the office before or by the end of the **first day of the next month**. Reimbursements to staff will be made on the next following payday. If expense reimbursement forms are not submitted by the deadline, there is a risk of not being reimbursed at all.

By signing below, I am stating that the reimbursement form is an accurate and true accounting of my expenses in accordance with authorized expenses and reimbursement policy. Further, I understand that any falsification of records is not acceptable to SHC and may be grounds for termination.

Employee Signature: _____ Date: _____

Supervisor Signature: _____ Date: _____