

INDIVIDUALISED FUNDING CLIENT EXPENSE REIMBURSEMENT

IF CLIENT NAME: _____

TO: LIFEWISE HEALTH AND DISABILITY

IF CLIENT NUMBER: _____

EMAIL: timesheets@lifewise.org.nz

This form must be sent to the above email before 12.30pm on the Monday payroll deadline.

From: _____

Name of the person being reimbursed/refunded.

Email address of person being reimbursed: _____

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: _____