



2260 Cliff Road
 Eagan, MN 55122
 P: 651.895.8030 F: 651.895.8070

EXPENSE REIMBURSEMENT REQUEST

Employee Name (please print): _____

Program (circle one): **ILS** **InHome** **GrpHome** **Admin** **RN/LPN** **Other** _____

All expenses must be pre-approved. Expenses other than mileage must be accompanied by receipts. A record of mileage must be attached to this form, for mileage reimbursement.

Transportation

Total number of miles _____ x .30 cents per mile (AHC) = \$ _____

Total number of miles _____ x .30 cents per mile (AHS) = \$ _____

Parking (receipts attached) = \$ _____

Other (please specify) _____ = \$ _____

Meals

(receipts attached) = \$ _____

Lodging

(receipts attached, as pre-approved) = \$ _____

Other

(please specify) _____ = \$ _____

_____ = \$ _____

_____ = \$ _____

_____ = \$ _____

TOTAL = \$ _____

I certify that the above expenses are accurately reported.

Employee Signature _____
Date

Supervisor Signature _____
Date

Payroll Signature _____ _____
Date Paydate

