Trinity Assistance Corporation
Monthly Expense Reimbursement Claim

Any expense report not submitted after **60 days** from the last day of the month in which expenses were incurred may NOT be reimbursed.

Fiscal Intermediary: Trinity Assistance Corporation				
Participant Name:		**Name of Person to be Reimbursed:**		
Month/Year:			**FI USE ONLY**	
Date	**Description**	**Cost**	**IDGS**	**BSSD**
	TOTAL EXPENSES			
		TOTAL UNITS		

ATTACH ALL ORIGINAL RECEIPTS/SERVICE INVOICES AS REQUIRED

NOTE: Signing and submitting false information may lead to a charge of Medicaid fraud.

By signing this document, I confirm that I received/provided the above services and supports and that the statements made about these services and supports are true.

____________________ **Date** ____________________ Signature of Person Seeking Reimbursement

____________________ **Date** ____________________ Signature of Participant/Designee

FI Approval: __________ **Paid on:** ____________________

Report Expenses for ONE month <u>only for Family and EACH PAY PERIOD for Staff</u>