**Trinity Assistance Corporation**
**Monthly Expense Reimbursement Claim**

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

| **Fiscal Intermediary:** Trinity Assistance Corporation | | | | |
|---|---|---|---|---|
| **Particpiant Name:** | | **Particpiant's Medicaid ID:** | | |
| **Month/Year:** | | | **FI USE ONLY** | |
| **Date** | **Description** | **Cost** | **IDGS** | **BSSD** |
| | *(Report expenses for a single month ONLY)* | | | |
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| | **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 only.**