Flex Funds Reimbursement Entry Form

To be reimbursed for a Flex Fund (9000 code) purchase, an original itemized receipt needs to be included with this form and turned in within 30 days of the purchase date. **This form does not guarantee payment.** A Flex Fund Progress Note must be entered into FidelityEHR and approved by a CC Supervisor. This form can be used for multiple receipts for a single client. Please only include dates within the same month.

Provider Name : _____ Date: _____

Provider Address: _____

_____

Provider Phone #: _____

Provider Agency: _____

Method of Delivery to CCNY: ○ US Mail ○ Hand Deliver

send to:
CCNY Attn. Sherry
567 Exchange Street
Buffalo, NY 14210
(716) 855-0007 ext. 318

Care Coordinator: _____

CC Agency: _____

Case #: _____

Identified Client Name: _____

Recipient of Expense: _____

Explanation of Expense: _____

_____

Flex Fund Code:				
Dates of Purchase:				
Funds Spent:				
How Paid:				

Please specify if you paid with cash, debit, credit or check

Person or Agency to be Reimbursed:

- ○ Same As Provider (person completing this form)
- ○ Same As Care Coordinator
- ○ Care Coordination Agency
- ○ Different than above (fill out below)

Name: _____

Address: _____

_____

Account #: _____

Any Additional Information Regarding Payment:

For CCNY Office Use only:

Invoice #: _____

Invoice Date: _____

Check #: _____

Check Date: _____

Person/Date Received: _____

Receipt(s) attached:	
Scan form and receipt(s):	
Entered into database:	
Email agency contact:	
Copy scanned doc into shared:	

[updated 11.16.18]