

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 : YOUR NAME HERE

Date: TODAY'S DATE

Provider Address: WHERE YOU LIVE

Method of Delivery to CCNY: US Mail
 Hand Deliver

Provider Phone #: YOUR PHONE NUMBER

Provider Agency: THE AGENCY YOU WORK FOR

send to:

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

Care Coordinator: THE CARE COORDINATOR ON THIS CASE

CC Agency: THE CARE COORDINATION AGENCY

Case #: CASE NUMBER FOR CLIENT

Identified Client Name: IDENTIFIED CLIENT

Flex Fund Code: 9000 code 9000 code 9000 code 9000 code

Recipient of Expense: WHO WAS EXPENSE MADE FOR

Dates of Purchase: DATE 1 DATE 2 DATE 3 DATE 4

Explanation of Expense: THE GOAL RELATED TO THIS EXPENSE

Funds Spent: RECEIPT 1 RECEIPT 2 RECEIPT 3 RECEIPT 4

How Paid:

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

Person or Agency to be Reimbursed: **(ONLY CHECK ONE)**

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

Any Additional Information Regarding Payment:

ANY ADDITIONAL INFORMATION NEEDED TO PROCESS THE RECEIPTS BEING SUBMITTED.

Name: FILL THIS SECTION OUT IF THE CHECK IS

Address: GOING TO ANYONE/COMPANY THAT IS NOT LISTED IN THE ABOVE SECTIONS.

Account #: THE INVOICE OR REFERENCE #

PLEASE DO NOT FILL OUT ANYTHING BELOW THIS LINE:

Invoice #: _____

Invoice Date: _____

Check #: _____

Check Date: _____

Person/Date Received: _____

Receipt(s) attached:

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Scan form and receipt(s):

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Entered into database:

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Email agency contact:

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Copy scanned doc into shared:

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