iCare
FAMILY HEALTH SERVICES

EXPENDITURE RECONCILATION

INDIVIDUAL NAME: DATE OF CHECK:

PURPOSE OF CHECK:

CHECK NUMBER: CHECK AMOUNT:

Payable To:_____

THIS FORM MUST BE COMPLETED AND RETURNED WITH THE ORIGINAL RECEIPTS WITHIN 30 DAYS FROM THE DATE OF THE CHECK/FUNDS RECEIVED. FURTHER FUNDS WILL NOT BE ISSUED UNTIL ALL RECEIPTS HAVE BEEN RETURNED. THIS FORM SHOULD BE USED FOR GENERAL EXPENDITURES FOR EACH CLIENT.

	DESCRIPTION OF MERCHANDISE	VENDOR NAME (If Appropriate)	COST
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
		SUB TOTAL	
		FUNDS RETURNED TO AGENCY	

I CERTIFIY THAT I HAVE SEEN THE ABOVE LISTED ITEMS, AND THEY WERE PURCHASED FOR THE USE OF THE NAMED INDIVIDUAL.

_____ _____

(SIGNATURE OF RESPONSIBLE PERSON) (DATE)

PLEASE RETURN COMPLETED FORM TO:
ICare Family Health Services
6909 West Ray Road, Bldg. #15, Suite 150
Chandler, AZ 85226
(480) 344-3721

IT IS YOUR RSPONSIBILITY TO KEEP A COMPLETE COPY OF ALL RECEIPTS BEFORE YOU SUBMIT TO OUR OFFICE.

FOR ADMINISTRATIVE USE ONLY

RECEIPTS VERIFIED AND TOTALED BY:_____ DATE:_____