Funding Brokerage - Expense Claim for reimbursement

Name of Funding Recipient: ___________________________
Address: ____
Phone Number: ____________________________________
Email: ____

Spending authority & contact: _____ self
_____ other:
Name: ____________________________
Email: _____________________________
Phone number: _____________________

Receipt #	Date	Company	Description	Funding source					
				SSAH	Autism	Passport	ODSP	Other	Other
1									
2									
3									
4									
5									
6									
7									
8									
9									
10									
11									
12									
13									
14									
15									
16									
17									
18									
19									
20									
21									
22									
23									
24									
			Total:						

Attach numbered original receipts
Submit within 2 business after the last day of the month

Total payment: ____________________

Spending Authority: ______________________________ ____________________
Signature Date