

Fortnightly Expense Claim for Verified Support Delivered

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| --- | --- | --- | --- | --- | --- |
| **Date** | **Name of person****or organisation** | **Address/phone number** | **DOB** | **Total****Hours** | **Amount** |
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| **Date** | **Other expenses – description of expense (you must keep a receipt for these)** | **Amount** |
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|  |  |  |
|  |  |  |
| **Signature** |  | **Total** |  |

Please note: This does not constitute an invoice for contract care. You must include an invoice for all Contract care payments included in this Expense Claim.

|  |  |
| --- | --- |
| Fortnight Ending (dd/mm/yyyy) |  |
| Person’s Name (person receiving disability support) |  |
| Agent’s Name (person managing the funding if different to the person receiving the funding) |  |
| DeclarationI accept that:* I am fully responsible for the management of my Individualised Funding

I confirm, in relation to this claim for payment, that:* The below information is a true and accurate record of the services/supports/expenses provided
* I have complied with all my responsibilities in the Manawanui Service Agreement and the Ministry

of Health’s Standard Agreement Declaration – Service Agreement* All services/supports/expenses for which I have claimed payment have been incurred by me as at the date of this claim
* I have made, and will retain, full records supporting this claim. I will make these records available for audit on request.

 Expenditure claimed for the fortnight (**you must identify each person providing support every time**) |
| Date (dd/mm/yyyy) |  | TIP: Emailed expense claims require your typed name and date as substitute for a signature, however please keep all originals and receipts for auditing purposes. |

Please email this Expense Claim Form to: accounts@incharge.org.nz.

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