

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) | | |  |
| Declaration  I 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.](mailto:accounts@incharge.org.nz)

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