



Financial Management Services

Attn: DDS A/P Processing Department
 P.O. Box 509, E. Windsor, CT 06088-0509
 Phone: (860) 627-9500 - Toll Free (866) 275-1358
 Fax: (860) 627-0330 - Toll Free (866)598-2ACR(2227)
 www.acrfi.org

REQUEST for REIMBURSEMENT

- Request for Prepaid expenses (MUST attach pre-printed receipts or invoices).
- Transportation (MUST attach receipts with provider's name imprinted on it).
- Respite (MUST attach copies of cancelled checks or receipts).

****Reimbursements will be processed for the total dollar amount of receipts provided with this Request for Reimbursement Form****

CONSUMER NAME:					
Date	Description/Purpose	Consumer	Provider	Provider Name	Amount
		<input type="checkbox"/>	<input type="checkbox"/>		
		<input type="checkbox"/>	<input type="checkbox"/>		
		<input type="checkbox"/>	<input type="checkbox"/>		
		<input type="checkbox"/>	<input type="checkbox"/>		
		<input type="checkbox"/>	<input type="checkbox"/>		
		<input type="checkbox"/>	<input type="checkbox"/>		
		<input type="checkbox"/>	<input type="checkbox"/>		
		<input type="checkbox"/>	<input type="checkbox"/>		
		<input type="checkbox"/>	<input type="checkbox"/>		
		<input type="checkbox"/>	<input type="checkbox"/>		
		<input type="checkbox"/>	<input type="checkbox"/>		
		<input type="checkbox"/>	<input type="checkbox"/>		
		<input type="checkbox"/>	<input type="checkbox"/>		
Total Amount					
Make check payable to:				TOTAL AMOUNT:	
Mailing Address:					

***By signing below, I certify that this request for reimbursement recorded on this reimbursement form were incurred expenses for the consumer or incurred while providing supports to the consumer listed above.**

Employee Name (Printed)Employee SignatureDate

***By signing below, I certify that the employee incurred expenses recorded on this reimbursement form for the consumer or while providing supports to the consumer listed above.**

Client/Representative Name (Printed)Client/Representative SignatureDate



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Receipt's Documentation

Provider Name: _____ Client Name _____
of Receipts _____ Page _____ of _____ Total \$ _____
