2260 Cliff Road, Eagan, Minnesota 55122

Phone: 651- 895-8030 Fax: 651-895-8070

EXPENSE REIMBURSEMENT REQUEST

Employee Name (please print): ______________________________

Program (circle one): **ILS** **InHome** **GrpHome** **Admin** **RN/LPN** **Other** __________

All expenses must be pre-approved. Expenses other than mileage must be accompanied by receipts.
A record of mileage must be attached to this form, for mileage reimbursement.

Transportation

Total number of miles ______ x .30 cents per mile (AHC) = $ __________

Total number of miles ______ x .30 cents per mile (AHS) = $ __________

Parking (receipts attached) = $ __________

Other (please specify) ______________________ = $ __________

Meals

(receipts attached) = $ __________

Lodging

(receipts attached, as pre-approved) = $ __________

Other

(please specify) ______________________ = $ __________

______________________________ = $ __________

______________________________ = $ __________

______________________________ = $ __________

TOTAL = $ __________

I certify that the above expenses are accurately reported.

______________________________ __________
Employee Signature Date

______________________________ __________
Supervisor Signature Date

______________________ __________ __________
Payroll Signature Date Paydate

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Alliance Health Care

MILEAGE RECORD

Employee Name (please print): ______________________________

Program (circle one): **ILS** **InHome** **GrpHome** **Admin** **RN/LPN** **Other**

Client Name (if applicable, please print): ______________________________

Date	Client	Destination	Odometer Begin	Odometer End	Total Miles
				Total Miles	

Employee Signature ______________________________ Date ______________

Payroll Signature ______________________________ Date ______________ Paydate ______________