HALO NETWORK OF SERVICES
221 BROADWAY, STE 206,
AMITYVILLE, NY 11701
631-789-7373
selfdirection@halonetworkinc.com

Self-Hired Support Staff Expense Report

For the Month of: _____ Participant's Name: _____

Check Payable To: _____

Address: _____

ONE MONTH PER EXPENSE REPORT

DATE OF EXPENSE	ACTIVITY	BUDGET CATEGORY	EXPENSE AMOUNT	APPROVED AMOUNT FOR OFFICE USE ONLY
	MILEAGE	**IDGS**		
	STAFF ACTIVITIES: MEAL	**OTPS**		
	STAFF ACTIVITIES: TICKETS	**OTPS**		
	STAFF ACTIVITIES: OTHER	**OTPS**		
		TOTAL		

☐ EXPENSE REPORT
☐ RECEIPTS
☐ IDGS MILEAGE

I attest that the documented expenses incurred were provided for the participant noted above

_____ _____
Signature of staff person seeking expense reimbursement Date

_____ _____
Signature of Participant Designee (required) Date

FOR OFFICE USE ONLY

TOTAL PAID FOR OTPS		TOTAL PAID FOR IDGS	

TOTAL PAID	

Note:

Check #: _____ Date of Disbursement: _____

**** Signing and submitting false information may lead to charges of Medicaid Fraud. ****