BLAIR SENIOR SERVICES, INC. Rev. 6/17/04

MONTHLY PURCHASE REQUEST FOR REIMBURSEMENT

Caregiver Name: _____ Paid During the Month of: _____

Item	**Amount of Purchase**	**Name of Store or Vendor Where Purchased**

Total Amount: .....

I AFFIRM THAT THE ABOVE ITEMIZED EXPENSES ARE TRUE AND CORRECT AND WERE INCURRED ON BEHALF OF MY CAREGIVING SITUATION. I ALSO AFFIRM THAT NONE OF THE ABOVE COSTS ARE FOR SERVICES PROVIDED BY A RELATIVE OF EITHER MYSELF OR MY CARERECEIVER. I FURTHER UNDERSTAND THAT ANY FALSIFICATION OF INFORMATION, PURCHASES, AND/OR ACTUAL COSTS WILL RESULT IN MY REIMBURSING BLAIR SENIOR SERVICES, INC.

_____ _____

Caregiver Signature Date Care Manager's Signature Date

_____

Supervisor's Signature Date