

Community Living Network

dba Community Alliance
301 W. Michigan Ave suite 102
734-482-3300 Fax 734-482-3894

Financial Supports Reimbursement Payment

Date: _____ Consumer: _____ County _____

Payee Information

Name: _____

Address: _____

Service Provided	Cost	Budget Item*

Total Reimbursable Amount: \$ _____

***Budget Item Choices:** Community Integration, Transportation, Personal Assistant Training, Professional or Clinical Services, Work Comp Insurance, Driver's License Check

****BE SURE TO INCLUDE ALL RECEIPTS****

By signing below, I certify and attest that the services listed were provided for the consumer listed above.

Employer/Guardian Signature Date

CLN Approval

*Rev. 05/11/2018; 08/02/18