MISSOURI DEPARTMENT OF HEALTH AND SENIOR SERVICES

MONTHLY EXPENSE REPORT

MONTH	*DOCUMENT NO.*		
VENDOR NO. (SOCIAL SECURITY NO.)	☐ DIRECT (ACH) ☐ AGENCY (CHECK) ☐ HOME (CHECK)	PAGE ______ OF ______	
EMPLOYEE NAME (LAST, FIRST)			
HOME ADDRESS (Only needed if HOME (CHECK) is marked)	DEPARTMENT/DIVISION OR INSTITUTION		
OFFICE ADDRESS	WORK PHONE NO.	UNIT/COUNTY	LOCATION CODE

DATE	FROM/TO & PURPOSE	RET (X)	MILES	BREAKFAST	LUNCH	DINNER	LODGING	BUS/R.R./ AIR - CAR RNTL EXP.	MISC.*	TOTAL
TOTALS OF ABOVE »										
TOTALS FROM OTHER PAGES »										
TOTAL MILES »					**AT $0.345 PER MILE**					

TOTAL INSTATE $	TOTAL OUTSTATE $	**TOTAL REIMBURSABLE EXPENSE »**

DATE	* EXPLANATION OF MISCELLANEOUS				

I hereby certify that I have reviewed the above claim and that the expenses are accurate and in compliance with DHSS and OA Policy.

I hereby certify the above claim is correct, that these expenses were necessary to conduct state business, that payment has been made from personal funds for which I have not been reimbursed, nor will I receive from any source any payment for these expenses.

APPROVAL SIGNATURE		CLAIMANT SIGNATURE	DATE
APPROVAL NAME (PLEASE PRINT OR TYPE)		CLAIMANT NAME (PLEASE PRINT OR TYPE)	
TITLE	DATE APPRVD	TITLE	OFFICIAL DOMICILE
VERIFIED BY		DATE	