**Evergreen Youth & Family Services, Inc.**

**FLEX FUND REIMBURSEMENT FORM**

**EMPLOYEE**

**SOCIAL SECURITY LAST 4#:**

Request reimbursement for the attached expenses incurred by myself or members of my family. Reimbursement request will not be processed without acceptable evidence of your expenses. Acceptable evidence includes receipts, statements, or explanation of benefits, which contain the following information:

1. Type of service or product provided.

2. Date expense incurred.

3. Name of employee or dependent for whom service or product provided.

4. Person or organization providing service or product.

5. Amount of expense.

(Items I, 2, 3, & 4 should be stated on receipts attached to this request)

 **Code:**

Medical Expense $      **251**

Daycare/Childcare Expense $      **252**

**MAKE CHECK PAYABLE TO:**

I hereby certify that all information is correct. I have not received reimbursement previously for these expenses and I know of no facts that make one question whether this expense is properly reimbursable under this plan. I further understand that this reimbursement is not a guarantee that this payment is tax-free and the reimbursable expense cannot be used to claim a deduction on my personal income tax return.

Employee Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_

**This section must be completed if you are claiming more than is currently in your flex fund account.**

If, as an Evergreen House employee, claim flex fund reimbursement inexcess of the amount currently in my flex fund, I agree to repay the excess at regular intervals by payroll deduction within the same flex plan year for as long as I am employed; or to repay the excess as a lump sum deducted from my final paycheck upon termination of employment with the agency. This is a voluntary authorization upon my part as an employee, pursuant to Minnesota statute number I 81.79 subdivision I (c).

Employee Signature: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_