



235 Nicoll Street
 Second Floor
 New Haven, CT 06511

TELEPHONE: (203) 562-2095
 FAX: (203) 562-1798
 EMAIL: info@irisct.org
 WEB: irisct.org

CO-SPONSOR REIMBURSEMENT COVER SHEET

Please submit separate cover sheets for each payee

Please note:

- All reimbursement requests should be made within 7 days of the expense.
- All requests must be submitted by the 75th day of the R&P period.
- All receipts must have been signed by all adults in the case before reimbursement can be processed

Client Name: _____ Co-sponsor Group: _____

Request Submitted by: _____

Reimbursement made payable to (**please print**): _____ (name)
 _____ (address)

Expenses to be reimbursed (*check all that apply*):

Expenses	Amount	Expenses	Amount
<input type="checkbox"/> Rent	_____	<input type="checkbox"/> Over-the-counter medications (only if prescribed)	_____
<input type="checkbox"/> Renter's insurance (1 month if req. by landlord)	_____	<input type="checkbox"/> Furniture including bedding	_____
<input type="checkbox"/> Pocket money	_____	<input type="checkbox"/> Household items incl. toiletries, cleaning supplies, linens, etc.	_____
<input type="checkbox"/> Cell phone (incl. 30 days service)	_____	<input type="checkbox"/> Car seats (\$25 – booster \$75 – infant \$50 - toddler/intermediate)	_____
<input type="checkbox"/> Bus passes (3 months)	_____	<input type="checkbox"/> Hot meal (upon arrival)	_____
<input type="checkbox"/> Initial Groceries	_____	<input type="checkbox"/> Clothing (\$50 per person)	_____
<input type="checkbox"/> Utilities (first 30 days)	_____	<input type="checkbox"/> Baby items	_____
<input type="checkbox"/> New mattresses/box springs (\$150 for twin, \$200 for full/queen)	_____		_____

Total amount requested _____ **Total amount to be reimbursed** _____
 (to be completed by IRIS)

Submitter's Signature: _____ Date: _____

Complete the above form and send with receipt(s) by **email attachment** to:

Greg Marino: gmarino@irisct.org