**COST REIMBURSEMENT REQUEST**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Reservation/Rancheria Name

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Contact Person & Title

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

Contact Telephone & FAX Number

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Contact Email

The following expenses/costs have been incurred and are supported by attached documentation in accordance with the terms of the Memorandum of Agreement **(MOA) #: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Cost Category** | MOA  Authorized  Budget: | Prior  Reimbursement  (If any): | Current  Reimbursement  Request: | TOTAL: | MOA  Budget  Remaining: |
| Personnel:  Salaries/Wages: |  |  |  |  |  |
| Fringe Benefits: |  |  |  |  |  |
| **Total Personnel:** |  |  |  |  |  |
| Non-Personnel:  Travel: |  |  |  |  |  |
| Space Cost (Rental): |  |  |  |  |  |
| Consumable Supplies: |  |  |  |  |  |
| Equipment Lease/Purchase: |  |  |  |  |  |
| Consultant Services: |  |  |  |  |  |
| Contract Services: |  |  |  |  |  |
| Subcontractors: |  |  |  |  |  |
| Other Costs: |  |  |  |  |  |
| **Total Non-Personnel:** |  |  |  |  |  |
| **TOTAL:** |  |  |  |  |  |

I understand the Client Services and Contacts Report Form must be filed with this request and failure to include said report will cause a delay in receiving the requested reimbursement:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

AUTHORIZED SIGNATURE ONLY Printed Name & Title Date

**FOR NCIDC USE ONLY:**

|  |  |  |
| --- | --- | --- |
| * Approved * Denied | Authorized By: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_    Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Amount Paid: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ |