

NCVAN 2021-2023 Homicide Victim Services Reimbursement Form

AGENCY INFORMATION	RECIPIENT INFORMATION
Contact Name:	Recipient Name:
Agency:	Recipient Address: City: State: Zip:
Address: City: State: Zip:	Recipient Phone: Email Address:
Phone:	Homicide Victim's Name:
Signature Statement of Agency Representative I _____, by my signature am confirming that this recipient was not called as a witness for the state. Date: _____	Trial Date/Length: _____ Number to days attended by recipient: _____
TRAVEL	
<i>Rental Car – will be reimbursed at economy car rate, \$50/day</i>	
RENTAL CAR COMPANY: _____ LENGTH OF RENTAL: _____	TOTAL COST OF CAR \$
<i>Personal Car Usage (.55 cents per mile, no receipts needed)</i>	
MILES TRAVELED ROUND TRIP _____ @.55/mile	TOTAL MILEAGE TO BE REIMBURSED \$
<i>Airfare - One Trip per Trial Setting (\$500 cap per person round trip)</i>	
COST FOR ROUND-TRIP TICKET = \$ _____	TOTAL AIRFARE: \$
<i>Parking Fees at Hotel or Courthouse Parking/Tolls</i>	
TOTAL PARKING FEES \$ _____	TOTAL TOLL FEES \$ _____
HOTEL (Rate: \$67.30/night plus tax per room)	
Hotel Name: _____	
No. of People: _____	
Cost per Night: _____ Taxes per Night: _____ Total No. of Nights: _____	TOTAL LODGING \$
MEALS (Breakfast \$8.00; Lunch \$10.10; Dinner \$17.30) ITEMIZED RECEIPTS REQUIRED <i>Alcohol is not an allowable expense Gratuity is not reimbursable</i>	
<u>Breakfast:</u> No. of People: _____ No. of Days: _____	Total Breakfast Cost \$
<u>Lunch:</u> No. of People: _____ No. of Days: _____	Total Lunch Cost \$
<u>Dinner:</u> No. of People: _____ No. of Days: _____	Total Dinner Cost \$
Requests for reimbursement must be accompanied with original itemized receipts (labeled and dated) and mailed/faxed or with this form. Credit card receipts without itemized billing are not admissible. Keep a copy of receipts for your records. Grant ends September 30th.	Total of all Meals \$
GRAND TOTAL REQUEST FOR REIMBURSEMENT \$	
I affirm that the above information is true and correct to the best of my knowledge and that I was not called as a witness for the state. I affirm that I am seeking reimbursement for myself and the parties listed on this form as approved.	
_____ Signature of Recipient	
Approved By (Project Director)	Date

Return Completed Reimbursement Form(s) To:



North Carolina Victim Assistance Network
P.O. Box 32173 Raleigh, NC 27622
email: admin@nc-van.org
Phone: 919-831-2857 ext. 104 | FAX: 919-831-0824