**Supplemental Sheet F: MEDICAL EXPENSES**

**If necessary, please attach additional sheets using this format.**

**Medical Expense** *Please list each medical expense for which you are seeking reimbursement*

|  |  |  |  |
| --- | --- | --- | --- |
| Describe the Medical Expense | What Was the Out of Pocket Cost? | Date Medical Expense Was Incurred | |
| Name of Service Provider | Contact Person’s Name: | E-mail | Telephone: |
| Provider’s Address | City | State | Zip Code |

**Medical Coverage** *Please identify all sources of financial assistance for each expense, including family members or friends who may have covered your expenses.*

|  |  |  |
| --- | --- | --- |
| Coverage Source’s Name | Policy # - Acct # - Claim # | Contact Person’s Name: |
| Coverage Source’s Address | Source’s Telephone | Source’s E-mail/Fax |

**Medical Expense** *Please list each medical expense for which you are seeking reimbursement*

|  |  |  |  |
| --- | --- | --- | --- |
| Describe the Medical Expense | What Was the Out of Pocket Cost? | Date Medical Expense Was Incurred | |
| Name of Service Provider | Contact Person’s Name: | E-mail | Telephone: |
| Provider’s Address | City | State | Zip Code |

**Medical Coverage** *Please identify all sources of financial assistance for each expense, including family members or friends who may have covered your expenses.*

|  |  |  |
| --- | --- | --- |
| Coverage Source’s Name | Policy # - Acct # - Claim # | Contact Person’s Name: |
| Coverage Source’s Address | Source’s Telephone | Source’s E-mail/Fax |

**Please attach supporting documentation for each expense such as insurance statements,**

**invoices, copies of receipts, credit card statements, Explanation of Benefits, etc.**

**Supplemental Sheet G: MENTAL HEALTH EXPENSES**

**If necessary, please attach additional sheets using this format.**

**Mental Health Expense** *Please list each mental health expense for which you are seeking reimbursement*

|  |  |  |  |
| --- | --- | --- | --- |
| Describe the Medical Expense | What Was the Out of Pocket Cost? | Date Medical Expense Was Incurred | |
| Name of Service Provider | Contact Person’s Name: | E-mail | Telephone: |
| Provider’s Address | City | State | Zip Code |

**Mental Health Coverage** *Please identify all sources of financial assistance for each expense, including family members or friends who may have covered your expenses.*

|  |  |  |
| --- | --- | --- |
| Coverage Source’s Name | Policy # - Acct # - Claim # | Contact Person’s Name: |
| Coverage Source’s Address | Source’s Telephone | Source’s E-mail/Fax |

**Mental Health Expense** *Please list each mental health expense for which you are seeking reimbursement*

|  |  |  |  |
| --- | --- | --- | --- |
| Describe the Medical Expense | What Was the Out of Pocket Cost? | Date Medical Expense Was Incurred | |
| Name of Service Provider | Contact Person’s Name: | E-mail | Telephone: |
| Provider’s Address | City | State | Zip Code |

**Mental Health Coverage** *Please identify all sources of financial assistance for each expense, including family members or friends who may have covered your expenses.*

|  |  |  |
| --- | --- | --- |
| Coverage Source’s Name | Policy # - Acct # - Claim # | Contact Person’s Name: |
| Coverage Source’s Address | Source’s Telephone | Source’s E-mail/Fax |

**Please attach supporting documentation for each expense such as insurance statements,**

**invoices, copies of receipts, credit card statements, Explanation of Benefits, etc.**

**Supplemental Sheet H: PROPERTY LOSS EXPENSES**

**If necessary, please attach additional sheets using this format.**

*Please list in detail, your specific items below.*

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Item**  **Name** | **Detailed Description** | **Cost at time of purchase** | **Was the item insured?** | **Attached Supporting Documentation** |
| **Example:**  *Digital Camera* | *1 Canon PowerShot S95 Camera with 10 megapixels, 4x zoom, 3” LCD display and SD memory card slot.* | *$865.00* | *no* | *Receipt* |
|  |  |  |  |  |
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**Please attach supporting documentation for each expense such as copies of receipts, credit card statements, pictures of the items, etc.**

**Supplemental Sheet I: FUNERAL & BURIAL EXPENSES**

**If necessary, please attach additional sheets using this format.**

*Please list in detail, your requested expenses below:*

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Type of Expense** | **Detailed Description** | **Total Cost at time of purchase** | **Amount covered by other sources** | **Purpose of Expense** | **Attached Supporting Documentation** |
|  |  |  |  |  |  |
|  |  |  |  |  |  |
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**For each expense you must attach copies of supporting documentation.**

**Third Party Contributions:** Has any other person(s) such as a family member or friend, paid for

part of the out-of-pocket funeral and/or burial expenses for which you are seeking reimbursement?

If so, complete the chart below.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Person Who Paid** | **Contact Information for Person(s) Who Paid** | **Relationship Between Claimant and Who Paid** | **Amount Paid** | **For What Expense** |
| Name | Address, e-mail and telephone |  |  |  |
| Name | Address, e-mail and telephone |  |  |  |
| Name | Address, e-mail and telephone |  |  |  |

**Please attach supporting documentation for each expense**

**such as copies of receipts, credit card statements, etc.**

**Supplemental Sheet J: MISCELLANEOUS EXPENSES**

**If necessary, please attach additional sheets using this format.**

*Please list your specific expenses below.*

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Type of Expense** | **Detailed Description** | **Cost at time expense was incurred** | **Amount covered by other sources** | **Purpose of Expense** | **Attached Supporting Documentation** |
| *Example:*  *Phone bill* | *Phone charges from India to Knoxville, TN while in India attending to victim’s affairs – June/July 2004* | *$384.28USD* | *no* | *Putting victim’s affairs in order* | *Phone bill* |
|  |  |  |  |  |  |
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**For each expense you must attach copies of supporting documentation.**

**Third Party Contributions:** Has any other person(s) such as a family member or friend, paid for part of the out-of-pocket funeral and/or burial expenses for which you are seeking reimbursement?

If so, complete the chart below.

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| **Person Who Paid** | **Contact Information for Person(s) Who Paid** | **Relationship Between Claimant and Who Paid** | **Amount Paid** | **For What Expense** |
| Name | Address, e-mail and telephone |  |  |  |
| Name | Address, e-mail and telephone |  |  |  |