**Luverne Area Community Foundation**

**Designated Support Expense Form**

|  |  |
| --- | --- |
| **Organization or Person** |  |
| **Address**  |  |
| **Contact Person** |  |
| **Amount Needed** | $ |
| **Date Needed** |  |

Fund ID # (office only) \_\_\_\_\_\_\_\_\_\_\_\_\_

**Expense Description:**

**Please include copies of all receipts and a total of reimbursement requested.**

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

*Signature Date*

Please submit completed request to:

***Luverne Area Community Foundation***

***P.O. Box 623***

***Luverne, MN 56156***