

**Luverne Area Community Foundation**

**Program Services Expense Form**

**Name of Fund** \_\_\_\_\_

<b>Organization or Person</b>	
<b>Address</b>	
<b>Contact Person</b>	
<b>Amount Needed</b>	\$
<b>Date Needed</b>	

To whom should the check be made out to: \_\_\_\_\_

Address: \_\_\_\_\_

**Expense Description:**

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

Expense

Purpose

\_\_\_\_\_  
*Signature*

\_\_\_\_\_  
*Date*

Please submit completed request to:

***Luverne Area Community Foundation  
P.O. Box 623  
Luverne, MN 56156***