## THE ARC OF KONA

H & CBS Personal Assistance Program
Activity Fund Expense Form

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MONTH/YEA	.R		
PARTICIPANT'S NAME:		DSW PROVIDER:	
MAKE CHEC ADDRESS:	K PAYABLE TO:		
Date	Item Purchased	Purpose (must support IP goals)	Cost
		TOTAL REQUESTE	D
Parent/Legal Guardian		Date	For Internal Use
Arc of Kona Supervisor Staff Only		Date	Date Initials

**NOTE**: Attach original receipts with Participant's name and other pertinent information written on them. Keep copies for your records before submitting. All purchases must relate to IP Goals.