New York Council of Nonprofits, Inc.
Flexible Spending Account Claim Form

Attach all supporting documentation and send completed form to:

FAX	MAIL	SCAN/EMAIL
Fax #: (518) 689-1042	NYCON **Attn: FSA Administration** 272 Broadway Albany, NY 12204	cshumpis@nycon.org
To: FSA Administration		
Date: Pages:		

Company:
Employee: **Social Security #:** **Contact #:**

Health Care Flexible Spending Account (HCFSA)—Claim(s) for Reimbursement

PATIENT NAME	RELATION-SHIP	AGE = >24	DATE OF SERVICE	DESCRIPTION OF EXPENSE(S)	OFFICE USE ONLY	TOTAL
					Total	

FSA Debit Card Used? ☐ Yes ☐ No

Detailed Receipt(s)/Letter of Medical Necessity must accompany claim form
*****(CREDIT CARD Receipts/CANCELLED CHECKS not acceptable)*****

The information furnished by me in support of this application is true and correct to the best of my knowledge. I authorize and individual or organization to release any requested information to the Council of Community Services of New York State, Inc. with respect to this specific application. I understand that these expenses must qualify under applicable sections of the Internal Revenue code and certify that the are not eligible for reimbursement from any other source.

EMPLOYEE SIGNATURE: _____ **DATE:** _____

Questions? Candace Ellis-Shumpis (518) 434-9194 Ext. 130