

**Crime Stoppers Reimbursement Request 20\_\_-20\_\_**

**Organization:**

**Grant No.:**

**Salaried Employees Invoice Tracking**

✓ If your Organization did NOT report any salaried/hourly positions within the application, please select this checkbox, save the form and move on with the process.

**Reimbursement Period:**                      **through**

<b>Employee's Name</b>	<b>Check Date</b>	<b>Check Number</b>	<b>Check Amount</b>	<b>Total CS Hours</b>	<b>Ending Date of Pay Period</b>	<b>Employee's Net Check Amount</b>	<b>OAG Total Amount Approved</b>
<b>Employee's Taxes</b> (FICA, Medicare & Withholding)	<b>Total Employee's Deductions</b> (Life, Health & Dental Ins., Def. Comp.)		<b>Employer Paid Benefits</b> (FICA, Medicare, Life, Health, Dental, LTD Pension, WC etc.)		<b>Gross Payroll</b>	<b>Total Amount Requested to be Reimbursed</b>	

**Employer Benefit Breakdown**

<b>Employee Name</b>	<b>Item</b>	<b>Date</b>	<b>Check Number</b>	<b>Amount</b>
*	*	*	*	*

<b>Salary</b>	<b>Check Amount</b>	<b>Employee's Net Check Amount</b>	<b>Employee's Taxes</b>	<b>Employee's Deductions</b>	<b>Gross Payroll</b>	<b>Employer Paid Benefits</b>	<b>Total Amount Requested to be Reimbursed</b>	<b>OAG Total Amount Approved</b>
<b>Totals</b>	\$0	\$0	\$0	\$0	\$0	\$0	\$0	\$0

**OAG Comments**

**Signature of Authorizing Official**

**Authorizing Official Name and Title**

**Date**

**Signature of OAG Staff Member**

**OAG Staff Member Name and Title**

**Date**

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NOTE: This form must be completed each month by all Agencies with Salaried Employees requesting salary reimbursement and must be submitted with the Reimbursement Request/Expenditure Report.

A copy must also be kept on file at the Office of the Grantee along with supporting documentation and made available upon request by the Office of the Attorney General or its representative.