FAMILY & CHILDREN SERVICES A SOURCE OF HOPE

FOSTER PARENT MILEAGE REIMBURSEMENT FORM

(This is for out of county sibling visits and out of county <u>well child exams</u> ONLY)

Failure to submit reimbursement sheet within the month following the month of mileage, may result in denial of reimbursement

Please Print:
NAME OF CHILD:_____

NAME OF FOSTER PARENT: _____

CHILD'S WORKER:_____

Date	From (Location)	To (Location/Purpose)	# of Miles

TOTAL MILES _____

<u>TOTAL $ (# Miles x .36)</u> _____

Foster Parent Signature_____ Date_____

Approved for payment by_____ Date _____

** Mileage is reimbursed at $.39 per mile**