FAMILY & CHILDREN SERVICES A SOURCE OF HOPE

FOSTER PARENT REIMBURSEMENT FORM

(This is for out of county sibling visits and
<u>out of county well child and annual dental 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_____

TOTAL $ (# Miles x .34¢)_____

Foster Parent Signature_____ Date_____

Approved for payment by_____ Date _____

** Mileage is reimbursed at $.34 per mile**