Date Received by Fiscal: _____

FOSTER CARE MILEAGE REIMBURSEMENT

Foster Parent Name: _____ Month/Year: _____

Allowable Mileage Expenses

*Service Related- Medical, Optical, Dental, Hospital Trips, Counseling, Early Intervention, etc.
*School- Travel for required activities, such as IEP meetings, parent/teacher conferences, school/developmental evaluations, detentions, to and from school if no bussing available
*Agency- Visits, Semi-Annual Reviews, Case Planning Meetings, Court, etc.
*Training- *Out of County Training* (must have prior approval when 75 or more miles one way). If you are licensed by ACCS and live in another county, travel to Athens for training is not considered out of county training.

Date	Child(ren)- first and last names	Destination	Purpose	Miles

Total Mileage Requested: _____ miles @ .555 cents/mile= $_____

I verify the above expenses were incurred in caring for the above-named child(ren).

_____ _____
Foster Parent Signature Date

_____ _____
Agency Approval Date