	FOSTER CARE MILEAGE REIMBURSEMENT							
Foster l	Parent Name:	Month/Year:						
	Travel for required activities, such as IEP n *A	Allowable Mileage Expenses elated- Medical, Optical, Dental, Hospital Trips, Counseling, Early Intervention, etc. neetings, parent/teacher conferences, school/developmental evaluations, detentions, to a Agency- Visits, Semi-Annual Reviews, Case Planning Meetings, Court, etc. or approval when 75 or more miles one way). If you are licensed by ACCS and live in training is not considered out of county training.		_				
Date	Child(ren)- first and last names	Destination	Purpose & Time	Miles				
		City & Place (must list address not just name)	-					

Date Received by Fiscal:

	Total Mileage Requested: _	miles @ .67 cents/mile= \$	
I verify t	the above expenses were incurred in	caring for the above-named child(ren).	
Foster Pa	arent Signature	Date	
Agency .	Approval	Date	