

Date Received by Fiscal: _____

FOSTER CARE MILEAGE REIMBURSEMENT

Foster Parent Name: _____ **Month/Year:** _____

Foster Home Address:_____

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.

[illegible]

Total Mileage Requested: _____ miles @ .76 cents/mile= \$ _____

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

Foster Parent Signature

Date

Agency Approval

Date