Medical Travel Reimbursement Rate Schedule

Month/Year ____________________

Medical travel for the approved recipient will be reimbursed at the agency's per diem rate. These rates will fluctuate periodically due to economic factors in the state.

Mileage – The amount will be calculated by the agency staff utilizing point to point mileage.

Meals – Receipts are required.

Lodging – Receipts for the recipient are required.

Recipient's Name: ____________________ County: ____________________

Date	Place Left	Time Left AM/PM	Place Arrived	Time Arrived A/M/PM	Miles	Mileage Amount	Lodging	Breakfast	Lunch	Dinner	Total

All recipients of the Family Support Program sign an annual Service Plan with the agency.
The Service Plan documents the service and amount approved for the year.
This Reimbursement Form is to reimburse you for the approved medical travel.