KVC- Behavioral HealthCare – KVC REIMBURSE ONLY FOR WHAT IS LISTED BELOW

FOSTER PARENT MILEAGE REPORT

Provider Name: _____

Provider Address: _____ **Month:** _____

City: _____ **State:** _____**Zip:** _____ **Year:** _____

Child's Name	Date	Destination	Odometer (Beginning)	Odometer (Ending)	Total Miles	Reason for Mileage		
		From: To:				☐Family Visit _____ (Family Member)		☐Court Hearing ☐Case Plan
		From: To:				☐Family Visit _____ (Family Member)		☐Court Hearing ☐Case Plan
		From: To:				☐Family Visit _____ (Family Member)		☐Court Hearing ☐Case Plan
		From: To:				☐Family Visit _____ (Family Member)		☐Court Hearing ☐Case Plan
Mileage Grand Total and Reimbursement Amount						**x $.34/ mi. = $**		

Please return this form by the 5th of each month to: Accounting Services, 21350 W. 153rd Street Olathe, KS 66061

I attest that the above information is accurate and represents mileage incurred in the performance of my Foster Parent responsibilities.

Signature: _____ **Date:** _____