KVC- Behavioral HealthCare

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		
						• Family Visit __________ (Family Member)	• Other __________	• Court Hearing • Case Plan
						• Family Visit __________ (Family Member)	• Other __________	• Court Hearing • Case Plan
						• Family Visit __________ (Family Member)	• Other __________	• Court Hearing • Case Plan
						• Family Visit __________ (Family Member)	• Other __________	• Court Hearing • Case Plan
						• Family Visit __________ (Family Member)	• Other __________	• Court Hearing • Case Plan
						• Family Visit __________ (Family Member)	• Other __________	• Court Hearing • Case Plan
						• Family Visit __________ (Family Member)	• Other __________	• Court Hearing • Case Plan
Mileage Grand Total and Reimbursement Amount						**x $.34/ mi. = $**		

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

Signature: ____ **Date:** __________________

Revised 7/8/05