



## FOSTER PARENT MILEAGE REIMBURSEMENT REQUEST FORM

MONTH \_\_\_\_\_ YEAR \_\_\_\_\_

**CHILDREN SERVICES  
DIVISION**

**FOSTER PARENT NAME:** \_\_\_\_\_

**FOSTER PARENT ADDRESS:** \_\_\_\_\_

**MAIL THE COMPLETED FORM TO:**

STARK COUNTY JFS  
ATTN: CHILDREN SERVICES BOOKKEEPING  
221 THIRD STREET SE  
CANTON, OHIO 44702

PLEASE PRINT - INK ONLY!

DATE	NAME OF CHILD(REN) TRANSPORTED	PLEASE INCLUDE NAME OF MEDICAL FACILITY		PURPOSE OF TRAVEL	MILEAGE WHOLE NUMBERS ONLY
		FROM FULL ADDRESS	TO FULL ADDRESS		
				<input type="checkbox"/> Medical Appt <input type="checkbox"/> Other, specify ↓	Round Trip? <input type="checkbox"/> Yes <input type="checkbox"/> No TOTAL:
				<input type="checkbox"/> Medical Appt <input type="checkbox"/> Other, specify ↓	Round Trip? <input type="checkbox"/> Yes <input type="checkbox"/> No TOTAL:
				<input type="checkbox"/> Medical Appt <input type="checkbox"/> Other, specify ↓	Round Trip? <input type="checkbox"/> Yes <input type="checkbox"/> No TOTAL:
				<input type="checkbox"/> Medical Appt <input type="checkbox"/> Other, specify ↓	Round Trip? <input type="checkbox"/> Yes <input type="checkbox"/> No TOTAL:
				<input type="checkbox"/> Medical Appt <input type="checkbox"/> Other, specify ↓	Round Trip? <input type="checkbox"/> Yes <input type="checkbox"/> No TOTAL:
				<input type="checkbox"/> Medical Appt <input type="checkbox"/> Other, specify ↓	Round Trip? <input type="checkbox"/> Yes <input type="checkbox"/> No TOTAL:
				<input type="checkbox"/> Medical Appt <input type="checkbox"/> Other, specify ↓	Round Trip? <input type="checkbox"/> Yes <input type="checkbox"/> No TOTAL:
<b>TOTAL:</b>					

Traveler's Certificate

I hereby certify that the statements made hereon are true, that the mileage listed was actually driven on county business, and that the expenses incurred were in accordance with state and county regulations. I also certify that I have liability insurance as required in ORC 4509.51

FOSTER PARENT'S SIGNATURE: _____	DATE: _____
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Authorization: \_\_\_\_\_ Approval: (up to \$250) \_\_\_\_\_  N/A (under \$250)

\_\_\_\_\_  
Social Services Worker      Date      Supervisor      Date      Program Administrator      Date