

**FOSTER PARENT REIMBURSEMENT FORM**

Foster Parent(s): \_\_\_\_\_ Provider ID# \_\_\_\_\_

Address: \_\_\_\_\_ Telephone # \_\_\_\_\_

**Expense Type:**

- 1) Mileage @ .44/mile
- 2) \*Telephone Calls @ .10/minute
- 3) \*Pre-Approved External Training
- 4) \*Other

**Approved Mileage:** Supervised Visits, Training, Treatment Team Meetings, Doctor/Dentist Appointments, Therapy, Therapeutic Groups

\*Please attach an **original** copy of your bill, receipt of purchase, External Professional Development Request, or telephone bill when submitting this form for reimbursement.

Date	Child's Name	Expense Type (1,2,3,4)	Explanation (Mileage: To, From, Purpose)	Miles	Total Amount Due
<b>Total Number Of Miles</b> ➡					
					<b>Total Amount Due</b> ➡

\_\_\_\_\_  
Foster Parent Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Approval Signature

\_\_\_\_\_  
Date

**Please Return to:**  
Community Care  
Attn: Reimbursement  
PO Box 936  
Bangor, Maine 04402-0936

**Expenses cannot be accepted if older than 60 days**