Stark County JFS
CHILDREN SERVICES DIVISION

FOSTER PARENT MILEAGE REIMBURSEMENT REQUEST FORM

MONTH ____________ YEAR_________

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 FROM FULL ADDRESS	 TO FULL ADDRESS	PURPOSE OF TRAVEL	MILEAGE WHOLE NUMBERS ONLY
				☐ Medical Appt ☐ Other, specify ↓	Round Trip? ☐Yes ☐ No TOTAL:
				☐ Medical Appt ☐ Other, specify ↓	Round Trip? ☐Yes ☐ No TOTAL:
				☐ Medical Appt ☐ Other, specify ↓	Round Trip? ☐Yes ☐ No TOTAL:
				☐ Medical Appt ☐ Other, specify ↓	Round Trip? ☐Yes ☐ No TOTAL:
				☐ Medical Appt ☐ Other, specify ↓	Round Trip? ☐Yes ☐ No TOTAL:
				☐ Medical Appt ☐ Other, specify ↓	Round Trip? ☐Yes ☐ No TOTAL:
				☐ Medical Appt ☐ Other, specify ↓	Round Trip? ☐Yes ☐ No TOTAL:
				TOTAL:	

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:

Authorization: Approval: (up to $250) ☐ N/A (under $250)

Social Services Worker Date ______ Supervisor Date ______ Program Administrator Date