OLMSTED COUNTY COMMUNITY SERVICES
FAMILY SUPPORT AND ASSISTANCE DIVISION
2117 CAMPUS DRIVE SE, SUITE 100
ROCHESTER, MN 55904-4825

REQUIRED DOCUMENTATION:

(We cannot reimburse you if this information is not available):

Receipts - attach all lodging , meals and non mileage transportation receipts

Olmsted County _does not_ reimburse for alcoholic beverages.

Mileage and parking - destination and purpose - **PARKING MUST SEND IN ORIGINAL RECEIPTS**

Mileage rate for vested interest vehicle (R)-.20 per mile (self, neighbor, friend, or relative)

Mileage rate for non-vested interest vehicle (NR)- IRS rate (volunteer drivers or organizations)

Prior Authorized Lodging- Not to exceed $50/day unless prior authorized.

Pre-approved Meals- Maximum including tax and gratuity: MUST SEND IN ORIGINAL RECEIPTS

(B) Breakfast- $5.50, (L) Lunch- $6.50 and (D) Dinner- $8.00

Please do not submit for reimbursement until you have a minimum of $20 in expenses

County will hold onto submitted reimbursement until minimum is met

MEDICAL TRANSPORTATION CLIENT EXPENSE REIMBURSEMENT FORM

RETURN TO ELIGIBILITY WORKER

MA Client's Name ____

MA Number_____________Sex________Date of Birth____________

Expense for the month of _________________________,20________

Make payment to : (Name of driver)

Name ____

Street/P.O. Box ____

City, State, Zip ____

Phone (____)___________________

DATE	REQUIRED DOCUMENTATION	Vehicle (R or NR)	# OF MILES	(Co Use Only) Mileage Amount	APPROVED MEALS AMOUNT	LODGING	PARKING	OTHER
	FROM				B			
	TO				L			
	PURPOSE OF TRIP:				D			
	DESTINATION:							
	NAME OF PERSON(S) SEEN:							
	FROM				B			
	TO				L			
	PURPOSE OF TRIP:				D			
	DESTINATION:							
	NAME OF PERSON(S) SEEN:							
	FROM				B			
	TO				L			
	PURPOSE OF TRIP:				D			
	DESTINATION:							
	NAME OF PERSON(S) SEEN:							

ACCOUNTING USE ONLY

TOTAL REQUEST FOR REIMBURSEMENT					

OFFICE USE ONLY

	INIT	DATE
GAX #		
ORDERED-GOODS RECD		
VERIFIED MATH FOR ACCURACY		
APPROVED FOR PAYMENT	DATE	
GAX TOTAL	VEND #	

FUND	DEPT	UNIT	OBJT	RPT

I hereby certify that I was Medical Assistance eligible during the period these expenses were incurred and that the expenses listed are accurate and eligible under the Medical Assistance program.

____
Claimant's Name- Printed

____
Claimant's Signature

****Reimbursements should be submitted at least quarterly or by the 10th of the month****

****We are unable to reimburse requests older than 11 months****

			(Co Use Only)		APPROVED			
DATE	REQUIRED DOCUMENTATION	Vehicle (R or NR)	# OF MILES	Mileage Amount	MEALS AMOUNT	LODGING	PARKING	OTHER
	FROM				**B**			
	TO				**L**			
	PURPOSE OF TRIP:				**D**			
	DESTINATION:							
	NAME OF PERSON(S) SEEN:							
	FROM				**B**			
	TO				**L**			
	PURPOSE OF TRIP:				**D**			
	DESTINATION:							
	NAME OF PERSON(S) SEEN:							
	FROM				**B**			
	TO				**L**			
	PURPOSE OF TRIP:				**D**			
	DESTINATION:							
	NAME OF PERSON(S) SEEN:							
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	TO				**L**			
	PURPOSE OF TRIP:				**D**			
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	DESTINATION:							
	NAME OF PERSON(S) SEEN:							
	FROM				**B**			
	TO				**L**			
	PURPOSE OF TRIP:				**D**			
	DESTINATION:							
	NAME OF PERSON(S) SEEN:							