SOUTHEAST FAMILY SUPPORT PROGRAM
PO Box 686
Yankton, SD 57078

EXPENSE REPORT

Name of Child:_____

Date of Appointment?_____ Name of Doctor or Clinic:_____ Did you stay over night?____How many nights?_____ Time of day you left:_____returned:_____ Did one or two parents go along?_____ From City_____To City_____	**Date of Appointment**?_____ Name of Doctor or Clinic:_____ Did you stay over night?____How many nights?_____ Time of day you left:_____returned:_____ Did one or two parents go along?_____ From City_____To City_____
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****** If your child has Medicaid, please call 1-866-403-1433 to get primary reimbursement through the Department of Social Services. Family Support will not provide funding for expenses that are covered through DSS.**

I certify that the above statements are true:_____
(Signature & Date)

Expense Report

Reimburse to:_____

Total Amount:_____

Date									Totals
Lodging									
Breakfast									
Lunch									
Dinner									
Mileage									

Breakfast -- $5.00 – leave before 5:30am, return after 8am
Lunch -- $9.00 – leave before 11:30am, return after 1pm
Dinner -- $12.00 – leave before5:30pm, return after 8pm

Lodging -- $46.50 plus tax – Standard Rate of Reimbursement (unless receipt is provided)

Mileage -- $0.37/mile

Mileage per www.freetrip.com = _____