

SOUTHEAST FAMILY SUPPORT 3 PROGRAM

1314 E. Cherry Street
Vermillion, SD 57069

EXPENSE REPORT

Name of Child: _____

<p>Date of Appointment? _____</p> <p>Name of Doctor or Clinic: _____</p> <p>Did you stay over night? _____ How many nights? _____</p> <p>Time of day you left: _____ returned: _____</p> <p>Did one or two parents go along? _____</p> <p>From City _____ To City _____</p>	<p>Date of Appointment? _____</p> <p>Name of Doctor or Clinic: _____</p> <p>Did you stay over night? _____ How many nights? _____</p> <p>Time of day you left: _____ returned: _____</p> <p>Did one or two parents go along? _____</p> <p>From City _____ To City _____</p>
<p>Date of Appointment? _____</p> <p>Name of Doctor or Clinic: _____</p> <p>Did you stay over night? _____ How many nights? _____</p> <p>Time of day you left: _____ returned: _____</p> <p>Did one or two parents go along? _____</p> <p>From City _____ To City _____</p>	<p>Date of Appointment? _____</p> <p>Name of Doctor or Clinic: _____</p> <p>Did you stay over night? _____ How many nights? _____</p> <p>Time of day you left: _____ returned: _____</p> <p>Did one or two parents go along? _____</p> <p>From City _____ To City _____</p>

****** 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 before 5:30pm, 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 = _____