CORTLAND COUNTY
DEPARTMENT OF SOCIAL SERVICES
FOSTER PARENT MILEAGE SHEET

CHILD'S NAME _____
MONTH OF _____
CASE NUMBER _____

TRIP DATE	*REASON FOR TRIP	LOCATION FROM	LOCATION TO	TOTAL MILES	45¢ PER MILE

*medical, dentist, counseling, etc

TOTAL $_____

Please submit mileage sheets for reimbursement within 90 days of rendering the services or payment will not be made.

_____
Foster Parent Signature

_____
Supervisor Signature

_____
Caseworker Signature

_____
Director Signature