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

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 (____)___________________

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

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

GAX #				INIT	DATE
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:							
	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:							
	FROM				B			
	TO				L			
	PURPOSE OF TRIP:				D			
	DESTINATION:							
	NAME OF PERSON(S) SEEN:							