PARTNERS in POLICYMAKING®

Year Class

PARTICIPANT REIMBURSEMENT EXPENSE FORM

WEEKEND DATE:

NOTE: The Partners progam may have a maximum dollar amount that can be reimbursed for child or respite care services on a monthly basis.	NUMBER OF HOURS		HOURLY RATE	AMOUNT
CHILD CARE *Child or Respite Care Reimbursement Expense Form for Provider must be completed, signed by provider, and attached.*		X		
RESPITE CARE *Child or Respite Care Reimbursement Expense Form for Provider must be completed, signed by provider, and attached.*		X		
TOTAL AMOUNT OWED FOR CHILD OR RESPITE CARE				

	NUMBER OF MILES		IRS MILEAGE RATE	AMOUNT
MILEAGE EXPENSE		X		
TOTAL AMOUNT OWED FOR MILEAGE				

MAKE CHECK PAYABLE TO: *(Check must be payable to the Partners participant, not a provider.)*

Name

Street Address

City State Zip

Signature of Claimant

MAIL TO: *Return this form and separate Child or Respite Care Reimbursement Expense Form for Provider (if claiming reimbursement for child or respite care services) within 2 weeks of the session to:*

Name

Street Address

City State Zip