Foster Parent Monthly Medical Transportation Claim

Erie County Department of Social Services
Division of Family Well-Being| AFS
B-1243 (9/2024)

Foster Parent Name	VID
Address	City / State / Zip Code

Child(ren) *

Name	CIN	Name	CIN
1.		3.	
2.		4.	

Transportation Type

☐ Private Auto License Plate #: ☐ Bus ☐ Other:

Date	*Child #	Roundtrip Address (Street Address, City, Zip) From	To	Starting Odometer Reading	Ending Odometer Reading	Roundtrip Total # Miles	Parking Fees (receipts required)	Tolls (receipts required)
				Subtotal:				
				Completed by Accounting	Rate per Mile:	$		
					Total:	$	$	$
					Total Mileage, Parking and Tolls:		**$**	

I, the undersigned, hereby certify that the mileage, parking fees and tolls indicated within this claim were necessary, traveled and incurred by the claimant and foster child(ren).

Foster Parent Signature _____ Date _____

☐ Approved

Caseworker or Homefinder Signature _____

Office Use Only

Unit: _____ SSTW: _____

SSTW Date Paid: _____ Date Scanned to Accounting: _____

Instructions:

To ensure prompt processing please:

- Sign and date the form.
- **Attach receipts for parking and tolls.**
- Roundtrip addresses
    - Print the street address, including city and zip code from which you start, usually your home address, in the “From” column.
    - Print the name and address, including city and zip code, of the medical facility or hospital you travelled to in the “To” column.
- Attach additional sheets as needed to accommodate all round trips.
- Mail completed form to:

    Erie County Department of Social Services

    2875 Union Road Suite 356

    Cheektowaga, NY 14227

    Attention: Homefinding

    -or-

    Email to:

    Homefinding@erie.gov

If you have any questions or concerns, please contact your Homefinder.