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|  | MISSOURI DEPARTMENT OF SOCIAL SERVICES  CHILDREN’S DIVISION  **TRAVEL EXPENSE LOG FOR CHILDREN IN FOSTER CARE** | | | | | | | | | | | | | | | | | | | | | |
| **- Fields 1-11 and 13-15 are to be completed by the Resource Provider requester**  **- Requests must be submitted to the worker within 30 days of the month when trip occurred.** | | | | | | | | | | | | | | | **1**. For The Month/Year Of: | | | | | | **2**. Page        Of | |
| **3**. Resource Parents (s): | | | | **4**. DVN: | | | | | **5**. Address: | | | | | | | | | | | | | |
| **6**. Child(ren’s) Name/DCN (If Split Mileage Include All) : | | | | | | | | | | | | | | | | | | | | | | |
| **7**. Worker Name: | | | | | | | | | | | | | | | | | | | | | | |
| **8.** Date of Travel  (MM/DD/YY) | | **9**. Address of Destination  (Street, City, Zip Code) | **10.** If Split Mileage List Names Of The Children | | **11**. Purpose of Travel | | | | | | | | | **12**. Other Allowable Transportation | | | | | | | |  |
| Medical | Counseling | Court | FST/PPR | | Family Visit | Respite | Education | Other Allowable | Other, Please Explain | | | Child’s Case Plan | FST Notes | Case Narrative | Court Order | | **13.** Round Trip Miles |
|  | | FROM:  TO: |  | |  |  |  |  | |  |  |  |  |  | | |  |  |  |  | |  |
|  | | FROM:  TO: |  | |  |  |  |  | |  |  |  |  |  | | |  |  |  |  | |  |
|  | | FROM:  TO: |  | |  |  |  |  | |  |  |  |  |  | | |  |  |  |  | |  |
|  | | FROM:  TO: |  | |  |  |  |  | |  |  |  |  |  | | |  |  |  |  | |  |
|  | | FROM:  TO: |  | |  |  |  |  | |  |  |  |  |  | | |  |  |  |  | |  |
| **14**. Resource Provider Signature: | | | | | | | | | | | | **15**. Date: | | | | Total Miles | | | | | | Box A |
| Worker Approval: | | | | | | | | | | | | Date: | | | | Current Mileage Rate at Time of Trip | | | | | | Box B      ¢ |
| Supervisor Approval: | | | | | | | | | | | | Date: | | | | **Total** Amount Reimbursed | | | | | | Box C $ |
| Regional Director/Deputy Director Approval if applicable: | | | | | | | | | | | | Date: | | | | | | | | | | |

**Travel Expense Log Information and Instructions-** **CD-106**

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| **PURPOSE:** This form is designed to provide a method for requesting monthly reimbursement of allowable transportation costs of resource providers. Accuracy and adherence to policy requirements and limitations are essential to be compliant with auditing programs. The reimbursement is at the current state mileage rate at the time of the travel using a Payment Request, PR.  **Allowable child specific transportation costs for vendors with AC, PP, behavioral or medical contracts include:** Medical care (ex. doctor, dentist, eye, WIC appointments, etc.), Counseling (ex. mental health appointments, etc.), Family Visits, Court, FST and PPR meetings, and Respite  **Other Allowable Child Specific Transportation:** Additional allowable child specific transportation trips are those intended to support the child’s development as approved by the Family Support Team and/or case manager and supervisor. The purpose must be identified in field 11 – Purpose of Travel: Other Allowable, Explain section.   * Transportation costs for any level of care for child care services (daycare, preschool, etc.) is **not** an allowable cost, even if such services are part of the child’s case plan.   **Education:** Acceptable child specific transportation also includes education related transportation needs to maintain the child in the school enrolled in to ensure educational stability.  **INSTRUCTIONS FOR COMPLETION:** The form is formatted to be completed electronically on-line, but may be printed and written by hand if desired (if writing by hand, please write clearly). Fields 1 through 11 and 13 through 15 of the form are completed by the resource provider. Field 12, Boxes A, B, and C are completed by the worker. MapQuest.com is used by the worker to verify the Round Trip Miles.  **Resource Provider Fills Out**:   * Field 1: Enter the month and the year that the travel occurred. * Field 2: Enter the number of pages included if applicable. * Field 3: Enter the name(s) of the resource parent(s). * Field 4: Enter the Department Vendor Number, DVN. * Field 5: Enter the complete home address including street address, city and zip code of the resource provider. * Field 6: Enter the name of the foster child (ren’s) name (s) and Department Client Number, DCN. * Field 7: Enter the name of the worker. * Field 8: Enter the date the travel occurred (**one date per line, please**). * Field 9: Enter the complete address of the destination (From/To). This information **must** include street address, city, and zip code. | **Resource Provider Fills Out (continued)**:   * Field 10: If the trip is being split between more than one foster youth, then list the name(s) of each child in this box. All the CD-106 forms for split mileage must be submitted at the same time. \*When there is more than one youth being transported for a trip, the trip mileage must be divided between each of the youth that were on the trip. This is a Federal, IV-E requirement. * Field 11: Check the appropriate box for the purpose of the trip. If the purpose of the trip is **other allowable**, identify the purpose. * Field 13: Calculate the mileage and write the round trip miles. * Field 14 and 15: **Resource provider must sign, date, and submit the form to the worker within thirty (30) days of the month that the trip occurred.**   **Worker Fills Out:**   * Field 12: If applicable, check the appropriate box indicating the type of other allowable transportation. * In **BOX A**, enter the total number of miles charged to the DCN. * In **BOX B,** enter the current mileage rate at time of trip. * Multiply the total number of allowable miles by the current mileage reimbursement rate at the time of the travel. * In **BOX C**, enter the dollar amount that resulted from the multiplication of Box A and Box B. * The worker will be sure that all CD-106 forms are attached to the PR. The worker will sign and date the CD-106 substantiating accuracy of the data entered. * Submit to supervisor for approval signature. * The supervisor will validate the accuracy of the CD-106 forms, sign, and date. * Submit to Regional Director and Deputy Director for approval if applicable. * The documents (PR, CD-106) are sent to FACES Financial Payment Unit. * The worker will make a copy of the CD106 and provide the copy to the resource provider prior to sending the form(s) to the FACES Payment Unit.   **Elevated Needs Level B:** The appropriate form to use for Level B (Career Level) resource providers is the CD-107.  **Non Child Specific:** Transportation reimbursement will be paid through SAM II to resource providers for trips to attend pre-service (after the license is approved and granted), in-service training, Foster Parent Advisory Board Meetings, State Foster Care and Adoption Board, and other meetings attended at the request of the state **using the Monthly Expense Report form, MO300-1189.** |