Partnership for Strong Families, Inc. Daytrip Travel Reimbursement Request for Level 2+ Foster Homes

Provider Name (Level II or higher Foster Home) _____ Provider ID _____

Date Purpose	Departure Time	Arrival Time	Departure Address (and Round-Trip Return Address) Arrival Address	FDOT Mileage	Mileage Claim	Parking and Tolls	Child Name Date of Birth	Total
1.					$0.00			$0.00
Purpose .	☐ Roundtrip			Return	Return $0.00	Return	DOB	
2.					$0.00			$0.00
Purpose .	☐ Roundtrip			Return	Return $0.00	Return	DOB	
3.					$0.00			$0.00
Purpose .	☐ Roundtrip			Return	Return $0.00	Return	DOB	
4.					$0.00			$0.00
Purpose .	☐ Roundtrip			Return	Return $0.00	Return	DOB	
5.					$0.00			$0.00
Purpose .	☐ Roundtrip			Return	Return $0.00	Return	DOB	
6.					$0.00			$0.00
Purpose .	☐ Roundtrip			Return	Return $0.00	Return	DOB	
7.					$0.00			$0.00
Purpose .	☐ Roundtrip			Return	Return $0.00	Return	DOB	
8.					$0.00			$0.00
Purpose .	☐ Roundtrip			Return	Return $0.00	Return $0.00	DOB	
				Column Totals:	0.00	$0.00	$0.00	Subtotal $0.00
				Unrounded Total Miles:	0.00	Rate/mile:	0.445	Less Any Advance
								Reimbursement Amount $0.00

I hereby certify or affirm that the expenses herein were actually incurred by me, a volunteering licensed foster parent, as necessary travel expenses in the performance of my official duties; and that this claim is true and correct in every material manner.

Signature

Foster Parent Date

Submit with attachments to invoices@pfsf.org

I, the Caregiver Support Specialist, hereby certify or affirm that the expenses herein were incurred in connection with official business of the organization.

Signature

Caregiver Support Specialist Date

Attach supporting documents and receipts.

INSTRUCTIONS

- There is a version of the Travel Reimbursement Request for each class of travel. This version is only used for day trips. This form is available as a fillable PDF or as a DocuSign form. Make certain that you complete the PDF version with a PDF Reader application, not an internet browser. If you do not have PDF software or if your PDF application is not calculating correctly, then you can submit the DocuSign version of the form with a web browser, but it must be correctly completed within 2 hours of starting.
- **Provider Name** should match the reimbursement payee name.
- **Provider ID** is your DCF Provider ID.
- The form has fields for 8 trips. Each trip on the form uses 2 rows to gather the required information. A trip can be a single journey, or one leg or a multi-destination journey, or a round-trip journey. A round trip means that the traveler returned directly to the point of origin after leaving the destination. The yellow-shaded fields on the second row are (only) used to enter information about the return portion of a round-trip.
- The **Date** is the trip date. Please do not put multiple months on one form.
- **Purpose** Select the approved business travel purpose from the options available from the pull-down menu on the first row for each trip. Conference is for day trips to an approved foster parent conference that is within 50 miles of your home. A copy of the agenda is required for conferences. Training is for day trips to an approved foster parent conference that is within 50 miles of your home. Court is for transporting a child in care assigned to PSF to and from their court hearings. Audiologist, Dentist, Doctor, Endodontist, Evaluator, Ophthalmologist, Optometrist, Therapist are for transporting a child in care assigned to PSF to and from their healthcare appointments. Visitation is for transporting a child in care assigned to PSF to and from visitations with their relatives.
- **Departure Time and Arrival Time** are either written in 12-hour or 24-hour format; for example, 3:33 PM or 15:33 but please don't mix time formats. The departure and arrival times are written in the first row for each trip. If the trip is a round-trip, then departure and arrival times for the return journey are written in the yellow shaded second row for each trip.
- **Departure Address (and Round-Trip Return Address)** The first row for each trip is for the Departure Address (Street, City, State Abbreviation, and Zip Code) on one line. If your journey is a round-trip, then this address also serves as the Return Address.
- **Arrival Address** The second row for each trip is for the Arrival Address (Street, City, State Abbreviation, and Zip Code) on one line. This address also serves as the departure address for round-trip journeys.
- **FDOT Mileage** Enter the exact mileage (to 2 decimal places) provided by the Florida Department of Transportation Official Highway Mileage Viewer (https://fdot.maps.arcgis.com/apps/webappviewer/index.html?id=fcb8b493d1c84f909f94a8ebfafbb317) for the addresses entered on the form. The column header is also a link to the site. In DocuSign the link is at the top of the page. Use the yellow shaded second row to enter the mileage for the return portion when the journey is round-trip. Note that the FDOT Official Highway Mileage Viewer is very precise and might provide different distances for each direction because actions like U-turns and left turns may increase the distance.
- **Mileage Claim** The form automatically calculates the claimed mileage amount by multiplying the distance in miles by the state's mileage rate.
- **Parking and Tolls** Enter the parking and toll expenses on the first row for each trip. Use the yellow shaded second row to enter the toll expenses for the return portion when the journey is round-trip. Receipts are required for all submitted parking expenses. A receipt or equivalent toll road operator documentation is required for all toll expenses that exceed $25 per transaction.
- **Child Name** This text field on the first row for each trip allows you to enter the name of the PSF assigned child in your care being transported.
- **Date of Birth** (DOB) This field on the second row for each trip allows you to enter the date of birth of the PSF assigned child being transported.
- **Totals** The form is designed to perform all the required calculations when you complete it with DocuSign, Adobe Acrobat or Foxit PDF.
- **Less any advance** is the amount paid in advance to a traveler pursuant to an Application for Advance of Travel Expense form (PSF-709). Enter the amount as a positive number.
- **Reimbursement Amount** is the amount that you are requesting. If the total results in a negative number, then please send your check for that amount made payable to: PARTNERSHIP FOR STRONG FAMILIES to:
  PARTNERSHIP FOR STRONG FAMILIES - FINANCE
  2850 NW 43RD ST STE 200, GAINESVILLE FL 32606-6966.
- **Dated Signatures** of the Licensed Caregiver (Level 2 or higher) and the Caregiver Support Specialist. DocuSign, Adobe and Foxit have built-in signature features. Only Level II or higher caregivers are eligible. Level I Licensed Caregivers are not eligible for Travel Reimbursement.
- **Attachments** The DocuSign version allows you to attach documents. Attachments to the PDF version can be attached to the same e-mail.
- **Submit** the completed form and any attachments to invoices@pfsf.org Please submit forms within 40 days from the oldest trip on the form and within 10 days from the most recent trip on the form.
- **Technical Support** Please inform your Caregiver Support Specialist if you are having difficulty completing this form so that support can be provided.