Out of Town Medical Travel Expense Claim – MCFD Salmon Arm

Foster Parent(s) Travelling	Resource Number:	Date:
Name:	Supplier Number:	Invoice Number: MT-
Address:	Phone No.:	
Location:	Child's Name:	CS File
Postal Code:	Child's Name:	CS File

Mileage Claim **Please Reimburse Me For:**			**Other Misc Claims** **(Accommodation, Taxi, Parking etc)**		
DATE	**TRAVEL TO & FROM**	**No. of KM's**	**DATE**	**DESCRIPTION OF CLAIM (RECEIPTS ATTACHED)**	**AMOUNT OF REIMBURSEMENT**
	Sub Total				
	(MCFD to complete)Total Mileage Claim Equals Kilometers x $0.51				
	(MCFD to complete) GRAND TOTAL				

Meal Claim Details

Date of Purchase	**Name of Person Meal Claimed For**	**Meal (ie breakfast, lunch, dinner)**	**Receipt(s) Total**	**Amount of Reimbursement (MCFD to Complete)**	INFORMATION FOR SUBMITTING MEDICAL TRAVEL CLAIMS
					Maximum meal reimbursement per person/per meal: Breakfast $11.75 Lunch $13.50 Dinner $22.75 or Daily $48.00
					*An itemized, detailed receipt must be submitted for each expense. We are unable to reimburse expenses from Debit Card/Credit Card receipts
					*All meal receipts must be submitted and attached to this form to be eligible for reimbursement *Receipts must reflect both what goods were purchased and the amount that was paid
					*Financial policy prohibits reimbursement of tips and alcoholic beverages

Foster Parent Signature: _____

Total Expense Claim Approved: _____

Qualified Receiver Signature: _____ Detailed Receipts Submitted: ☐

Please submit this invoice and original receipts to: MCFD – 550 Lakeshore Dr NE, Salmon Arm, BC V1E 4S4

MCFD Salmon Arm - Out of Town Medical Travel Expense Reimbursement Form Instructions

Name: Full name of Foster Parent(s)
Address: FP Address
Location: FP Address
Postal Code: FP Address
Resource Number: Number issued to FP by MCFD
Supplier Number: MCFD will complete
Phone Number: FP Phone Number
Child's Name: Name of Child for which the Medical Appointment applies
CS File Number: MCFD will complete

Mileage Claim

- Indicate date of travel
- Description of Travel
- Total Kilometers travelled – to
- Total kilometers travelled- return
- Sub Total (Total km to and Total km from =)
- Calculations and Grand Total (to be completed by MCFD)

Meal Claim Details

- Date Meal Purchased, Name of Person consuming the meal, Type of meal and $ value

Other Claim Details

- Date of Purchase -Description of Purchase - Reimbursement amount

Foster Parent Signature – Foster Parent signs off as Goods Received, and Paid for

REMAINING TO BE COMPLETED BY MCFD

Ensure all ORIGINAL ITEMIZED RECEIPTS are attached

- Original receipts are required – not copies
- Detailed receipts are required, the debit/credit card receipts are not sufficient unless it shows specifically what was purchased
- Meals will only be reimbursed to the maximum allowable per diem amount noted on the form per person per meal
- Fuel receipts need to be the final printed copy, not the pre-auth copy
- Financial Policy prohibits reimbursement of tips and alcoholic beverages
- The number of people and the type of meal provided needs to be indicated

Please submit this invoice and original receipts to: MCFD – 550 Lakeshore Dr NE, Salmon Arm, BC V1E 4S4