

Family Support Services Travel Expense Form

Enrollee's Name (please print) Driver's Name		Address				
		Address				
Driver's Social S	ecurity Number					
Date	From	То	Round Trip	Purpose	Total Mileage	
	atements made hereon are true, that the mileage			Total Miles (effective rate 10/1/21)		
	were in accordance with the policies of the Mediabile liability insurance.	na County Board of Developmental Disabilitie	es. I also certify	TOTAL \$		
Signature	Date	Signature	Signature of family member authorizing travel			
Do you	nent to answers these survey questions. Any info use the agency website (<u>www.mcbdd.org</u>) for inf uggestions do you have to improve the FSS prog	ormation about the FSS Program or to downl	load forms? 🗀 yes 🗀 no			
Submi	t to: MCBDD Attn. Medicaid Services Manager	, 4691 Windfall Road, Medina, OH 44256		Allotment Balance		

MCBDD-SSA Rev: 11/18/21-SP V:2 0309056 RC 2-R-69 Proc Ref: 722 Family Support Services Pol Ref: MCBDD Policy Ch. 7, Sec. 6

Scan/Email to: FSSinfo@mcbdd.org, Fax: 330-722-4854