Supported Living
Travel Expense Report

Enrollee's Name _____ Address _____ Phone _____
Driver's Name _____ Address _____ Phone _____
Driver's Social Security Number _____

Date	From	To	Purpose	Mileage

Total Miles _____
(Matched to waiver rate effective rate 1/1/22) **$0.60**
TOTAL $ _____

Traveler's Certificate

I certify that the statements made hereon are true, that the mileage was actually driven on official business and that the expenses incurred were in accordance with the policies of the Medina County Board of DD. I also certify that I have automobile liability insurance.

_____ _____ _____
Signature Date Signature of family member authorizing travel

Mail to: Medina County Board of DD, Attn: Medicaid Services Manager, 4691 Windfall Road, Medina, Ohio 44256
Scan/Email to: SLinfo@mcbdd.org Fax: 330-722-4854

(Extra forms available at www.mcbdd.org)

MCBDD
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RC-2: R-60