Family Support Services
Travel Expense Form

Enrollee's Name (please print) _____ Address _____ Phone _____

Driver's Name _____ Address _____ Phone _____

Driver's Social Security Number _____

Date	From	To	Round Trip	Purpose	Total Mileage

Travel'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 Developmental Disabilities. I also certify that I have automobile liability insurance.

Total Miles _____

(effective rate 1/1/24) **x** **$0.67**

TOTAL $ _____

_____ _____ _____

Signature Date Signature of family member authorizing travel

Please take a moment to answers these survey questions. Any information that you are able to share will help us with future planning.

Do you use the agency website (www.mcbdd.org) for information about the FSS Program or to download forms? □ yes □ no

What suggestions do you have to improve the FSS program? _____

_____

_____

Submit to: MCBDD Attn. Medicaid Services Manager, 4691 Windfall Road, Medina, OH 44256

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

Allotment Balance _____

MCBDD-SSA
Rev: 11/18/21
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RC 2-R-69
Proc Ref: 722 Family Support Services
Pol Ref: MCBDD Policy 7.6