UIC

TRAVEL ASSISTANCE COST LOG

DIVISION OF SPECIALIZED CARE FOR CHILDREN

PAYEE'S SOCIAL SECURITY NUMBER
PAYEE'S NAME AND COMPLETE MAILING ADDRESS

CHILD'S NAME _____

DSCC CASE NUMBER _____

If you receive a travel advance, you must return this form immediately. If you receive a travel advance and the future appointment is cancelled and not rescheduled within thirty (30) days of the original appointment, you must return this form and the advance immediately. Failure to do so will affect your eligibility for travel assistance. Your Care Coordinator must be notified of a new appointment.

1. Appointment/Educational Conference was at _____
   (give name of hospital, clinic, physician or conference)
   in _____. Appointment/Conference date _____
   (city, state)
2. Give date, time and place travel began _____
3. Give date, time and place travel ended _____
4. How did you travel? ☐ auto ☐ train ☐ airplane ☐ bus ☐ other _____
5. If by automobile, how many total miles (round trip)? _____
6. If by train, plane or bus did you pay for the ticket? ☐ yes ☐ no
   If yes, attach receipt. **TRANSPORTATION TOTAL** $_____
7. Did you stay overnight anywhere? ☐ yes ☐ no
   If yes, where? _____ How many nights? _____
   Did you pay the bill? ☐ yes ☐ no
   If yes, attach receipt. **LODGING TOTAL** $_____
8. For overnight meal allowance, who made the trip? **MEAL NUMBER** *(not to exceed 4)*
   ☐ Child, Parent/Guardian #_____, Other #_____. Total #_____ **MEAL TOTAL** $_____
9. Was the child hospitalized? ☐ yes ☐ no
10. Please list any additional traveling expenses (i.e. taxi, parking, conference fees, tolls) and the amounts.
    Attach receipt for each expense over $10.00. **MISCELLANEOUS TOTAL** $_____

    _____ **LESS ADVANCE** $_____

    _____ **FINAL TOTAL** $_____

REGIONAL OFFICE USE ONLY

I certify the expenses shown on the travel log were paid for services that were approved by DSCC.

PAYEE'S SIGNATURE _____ DATE _____

DSCC USE ONLY

VERIFICATION OF PAYEE & ADDRESS:

Payment: FRA _____ Spouse of FRA in same household _____ Other ____(must be enrolled in CPS)

I approve the reimbursement for the travel expenses indicated above. The travel approved complies with Policy 03-2.

CARE COORDINATOR/PCA CERTIFICATION _____ DATE _____

RM/ARM APPROVAL _____ DATE _____

********** SEE REVERSE SIDE FOR DETAILED INSTRUCTIONS **********

05.49 (Rev. 07/17) The University of Illinois at Chicago

WHAT YOU SHOULD DO TO BE REIMBURSED FOR TRAVEL FOR MEDICAL SERVICES.

- **PAYEE'S SOCIAL SECURITY NUMBER, NAME AND MAILING ADDRESS:** Enter the social security number, name and mailing address of the person to receive payment.
- If the payee (traveler to whom reimbursement is to be made) living in the same household as the financially responsible adult prefers to receive the reimbursement directly, the payee must be enrolled with DSCC as a provider.
- **CHILD'S NAME AND CASE NUMBER:** Enter the child's legal name and the Division of Specialized Care for Children (DSCC) six-digit case number.
- Sign and date the form.
- Send in original receipts for lodging and/or any expense over $10.00.
- Please send this reimbursement form within **thirty (30) days** from date of service.

HOW TO COMPLETE THIS FORM:

1. Insert name, location and date of appointment.
2. Insert date, time and place where the travel began (e.g., 3/14/10, 8 a.m., Lincoln, IL).
3. Insert date, time and place where the travel ended (e.g., 3/14/10, 2 p.m., Lincoln, IL).
4. Check the method(s) of transportation.
5. Write down total miles traveled if an automobile was used for travel. Mileage reimbursement for personal automobile is based on current University travel regulations in place at the time of the travel. Gasoline receipts are not required.
6. Attach receipt if you paid for any train, plane, or bus tickets.
7. If you stayed overnight, indicate name of lodging accommodations (i.e., XYZ Motel, Ronald McDonald House) and how many nights you stayed. Lodging cost can be supported for the parent(s) during a hospitalization if no other resources are available. Attach receipt if you paid the lodging bill (not direct-billed to DSCC). **Contact the Regional Office to obtain the maximum allowable lodging rates for in-state and/or out-of-state.**

   NOTE: A person who is handicapped may require special lodging considerations and may be reimbursed for the actual cost of the least-costly lodging which is handicap accessible.
8. Indicate the category and number of overnight travelers for the meal allowance.
9. Indicate if the child was hospitalized.

   NOTE: The meal allowance is $20.00 per overnight stay regardless of time travel began or ended for a maximum of four (4) individuals. The child is not included in the meal allowance when he/she is hospitalized.
10. List any additional expenses paid during the travel period (e.g., Parking $10.50, $3.00, $2.50; Tolls $.50). **Attach original receipts if expense exceeds $10.00. Receipts are not required for meals.**

PAYEE'S SIGNATURE: Signature of payee whose social security number is listed at top of form. Enter date signed.

REGIONAL OFFICE APPROVAL, DIRECT BILL INFORMATION, AND LINE TOTALS to be completed by DSCC Regional Office personnel.