DIVISION OF SPECIALIZED CARE FOR CHILDREN

TRAVEL ASSISTANCE COST LOG

PAYEE'S NAME AND COMPLETE MAILING ADDRESS

PARTICIPANT'S NAME _____

DSCC 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 must notify your Care Coordinator of a new appointment.

	REGIONAL OFFICE USE ONLY
1. Appointment/educational conference was at _____ *(give name of hospital, clinic, physician or conference)* in _____ *(city, state)*. Appointment/conference date _____	
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. Overnight meal allowance ($20 per family per overnight stay, i.e. $20 x #of nights). **MEAL TOTAL**	$_____
9. Please list any additional traveling expenses (e.g., taxi, parking, conference fees, tolls) and the amounts. Attach receipt for each expense over $10. Receipts for tolls are not required.	
_____ **MISCELLANEOUS TOTAL**	$_____
_____ **LESS ADVANCE**	$_____
_____ **FINAL TOTAL**	$_____

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:

Payee: Applying LRA ☐ ☐ Spouse in Same Household ☐ Other (must be enrolled)

I approve the reimbursement for the travel expenses indicated above. The approved travel complies with the Core Supported Services Policy.

CARE COORDINATOR/PCA CERTIFICATION: _____ DATE: _____

RM/ARM APPROVAL: _____ DATE: _____

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

WHAT YOU SHOULD DO TO RECEIVE REIMBURSEMENT FOR TRAVEL RELATED TO MEDICAL SERVICES:

- **PAYEE'S NAME AND COMPLETE MAILING ADDRESS:** Enter name and mailing address of the person to receive payment.
- If the payee (the traveler who should receive reimbursement) is not the applying legally responsible adult (LRA), the payee must be an enrolled provider with University of Illinois Chicago's Division of Specialized Care for Children (DSCC).
- **PARTICIPANT'S NAME AND DSCC NUMBER:** Enter the child's legal name and the DSCC six-digit number.
- Sign and date the form.
- Send in original receipts for lodging and/or any expense over $10.
- 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 used.
5. Write down total miles traveled if an automobile was used for travel. Mileage reimbursement for personal automobile is based on current Medicaid reimbursement rate 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). If lodging takes donations in lieu of a nightly rate, DSCC will reimburse you up to $20/day for lodging. The receipt should be attached to the travel log. DSCC cannot reimburse you for donations made in addition to the daily rate for lodging.

   Contact the Regional Office to obtain the maximum allowable lodging rates for in-state and/or out-of-state.

   NOTE: A person with disabilities may require special lodging considerations and may be reimbursed for the actual cost of the least-costly lodging which is disability accessible.

8. ***NOTE:*** The meal allowance is $20 per family per overnight stay. ($20 x # of overnights)
9. List any additional expenses paid during the travel period (e.g., Parking $10.50, $3, $2.50; Tolls $.50). **Attach original receipts if expense exceeds $10. Receipts are not required for meals.**

PAYEE'S SIGNATURE AND DATE: Signature of payee 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.