KINDRED FAMILY FOCUS
A NEXUS FAMILY MEMBER
YOUTH AND FAMILY SOLUTIONS

Foster Parent Reimbursement

Foster Parent(s): _____

Name of Youth: _____

County of Financial Responsibility: _____

Name of County Worker: _____

Date	*Description of Item(s) to be Paid (if claiming non-medical mileage list from & to)*	*Amount*	*Non-Medical Mileage*

TOTAL: *$_____* *$_____*

Please sign below and attach all invoices or receipts.

I verify this claim is accurate:

_____ _____
Foster Parent Signature *Date*

_____ _____
KFF Worker Signature *Date*