

CAREGIVER'S SUPPLEMENTARY EXPENDITURE AFFIDAVIT

Name of Caregiver:	Name of Child:	DATE: (No more than one month) From: To:
Caregiver TIPS Number:	Child TIPS Number:	

Mileage (Include Only Travel Approved by DCFS)

Date	Destination and Purpose of Travel	Odometer Reading		Miles Traveled	Amount miles x state rate
		Departure	Arrival		
TOTAL					

Educational Expenses	Medical	Clothing	Other
TOTAL COSTS			

Retainer Home Visitation - Date(s) of Visit(s):				

Receipts over 90 days will not be paid or reimbursed.

Receipts must be attached for each expenditure with child's name, store name, clerk's name or number and amount. The receipts are to be itemized. Purchases of clothing and other incidental needs for which you are requesting reimbursement require prior approval from DCFS.

I certify that these expenses were made by the above-named, that the child has received the benefits from them and that the prices of purchases are no higher than prices for the same quality of goods and services at other places where I could reasonably trade.	Caregiver Signature	Date
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