HENNEPIN COUNTY
HUMAN SERVICES AND PUBLIC HEALTH DEPARTMENT
FOSTER CARE PROGRAM
MISCELLANEOUS EXPENDITURE REIMBURSEMENT REQUEST

<table>
<thead>
<tr>
<th>Child's Name</th>
<th>Case Number</th>
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</thead>
<tbody>
<tr>
<td>IF MORE THAN 1 CHILD, WRITE NAME AND DOB BELOW</td>
<td>Child’s Case Number. Leave Blank if you do not know</td>
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</tbody>
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<table>
<thead>
<tr>
<th>Case Worker</th>
<th>Supervisor’s Approval Signature</th>
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<tbody>
<tr>
<td>The worker of the child/children</td>
<td>Supervisor of the licensor</td>
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<tr>
<th>Worker's Authorization Signature</th>
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<tr>
<td>Licensor of foster parent using Respite.</td>
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</table>

Date
The date you are completing the form.

ATTACH RECEIPTS FOR APPROVED EXPENDITURES

ITEMIZE EXPENDITURES - Include dates of service, mileage, etc. AMOUNT

1. Write Out of Home Respite on this line

2. Write the start and end date of the respite. LEAVE THIS

Full name of foster children and DOB. See Respite forms 1/2.

1. FULL NAME OF FOSTER CHILDREN AND DOB. LEAVE THIS AREA BLANK

2. FULL NAME OF FOSTER CHILDREN AND DOB. LEAVE THIS AREA BLANK

3. FULL NAME OF FOSTER CHILDREN AND DOB. LEAVE THIS AREA BLANK

4. FULL NAME OF FOSTER CHILDREN AND DOB. LEAVE THIS AREA BLANK

I hereby acknowledge receipt of the above services and/or commodities for the above-named child.

Foster Parent providing the Respite

Signature of Foster Parent

Foster parents are urged to submit this voucher as soon as possible to avoid delay in payment.

Return to: Licensor of foster parent using Respite. Check for correct address and mail code.

Social Worker
Health Services Building - 10 MC960
525 Portland Avenue South
Minneapolis, MN 55415-1569

Print your name, address, and your provider number in this area.