 **BOONE COUNTY FAMILY RESOURCES**

 **REIMBURSEMENT REQUEST**

**FOR REIMBURSED MILEAGE AND PARATRANSIT**

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| **RESPONSIBLE PARTY NAME:** | **CLIENT NAME:** | **SUPPORT COORDINATOR:** |

**CONDITIONS FOR PARTICIPATION I THE REIMBURSEMENT PROGRAM**

*Read Carefully*

1. BCFR’s reimbursement is limited to services/supports prior authorized in the Agency's authorization system. If you have questions regarding the authorized amount, please contact your Support Coordinator prior to submitting a Reimbursement Request.

2. You may submit reimbursement requests at any time during the authorized month, or within 90 days after the month of service. All required documentation must be fully completed and submitted together at the same time. Submit all dates of service together for a given month. Additional dates for the month will not be reimbursed after BCFR payment has been processed for that month.

3. Please submit complete and accurate reimbursement requests via mail or email to the attention of the Service Procurement Specialist, at the address noted on the front of this page, by the 5:00 pm 5th of the month to allow for reimbursement by the 20th of that month. Any request received after the 5th of the month or that were not fully completed by the 5th of the month, payment will be sent by the 20th of the following month, once fully completed. If the 5th falls on a weekend or holiday of which the Agency is closed, submission of requests are due by 5:00 pm on the following business day.

* Where to submit documentation:
	+ Email to: serviceprocurement@bcfr.org
		- If you do not have a scanner, a clear photo of front and back of form with all corners showing is sufficient.
	+ In Person or Mail: 2700 W Ash Street Columbia, MO 65203
		- Drop off at front desk between hours of 8:00AM and 5:00PM Monday to Friday.
		- After hours drop off: Drop in secure drop box outside of front door.

4. You are responsible to file for all applicable health insurance benefits. You are responsible for your deductible and the agency will only reimburse up to the established unit rate for the service and service duration during this time. You are responsible for any costs that are not covered by your insurance and are more than our established unit rate.

5. Reimbursement from this agency will not exceed the authorized amount or the established agency service limits and unit costs.

6. Complete this and other forms electronically or in ink. Please do not use white out. Strike through

 any errors.

This reimbursement is used for travel to and/or from services called for in my Individual Plan. I/Our family understand(s) and agree(s) to the follow the above conditions for transportation reimbursement. I certify the transportation has been rendered and I have not received, nor will I seek reimbursement for this transportation from any other source.

Responsible Party/Family Member Signature Date

If you need additional copies of this form contact your Support Coordinator or see the BCFR website at: <https://www.bcfr.org/services/support-coordination/reimbursed-services/>

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| **TRANSPORTATION REIMBURSEMENT REQUEST** |  |
| Transportation reimbursement is available for verifiable vocation and day programs, sheltered and supported employment, support groups, therapeutic recreation and independent living skills training. Reimbursement is also available for counseling, therapies and medical appointments not covered by Medicaid. The type, month and amount of the authorization for is stated on the opposite side of this form. |
| **PARATRANSIT REIMBURSEMENT:** is to be used for travel as noted in my Individual Plan and is reimbursable at $2.00 per trip.  |
| **MILEAGE REIMBURSEMENT:** can only be requested for the miles while the individual is in the vehicle being transported to or from an approved activity and is reimbursable at $0.25 per eligible mile. Only transportation within the state of Missouri can be reimbursed.  |
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| DATE | PURPOSE | FROM AND TO LOCATION | WHO TRANSPORTED YOU | PARATRANSIT TRIPS or REIMBURSED MILES |
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|   |   |   | RATE | X $      |
|   |   |   | AMOUNT REQUESTED | $      |