DANIEL P. MCCOY
COUNTY EXECUTIVE

GAIL GEOHAGEN-PRATT
COMMISSIONER

MOIRA MANNING
DEPUTY COMMISSIONER

COUNTY OF ALBANY
DEPARTMENT FOR CHILDREN, YOUTH AND FAMILIES
DIVISION FOR CHILDREN WITH SPECIAL NEEDS
112 STATE STREET ROOM 300
ALBANY, NEW YORK 12207
(518) 447-4820 - FAX (518) 447-4855

PARENT TRANSPORTATION REIMBURSEMENT

Return signed statement Attn: Transportation

Child's Name			**Date of Birth**	
Home Address	Street			
	City	New York State		Zip
Phone				
Program				
Program Address	Street			
	City	New York State		Zip
Phone				

		Transportation Dates		Days	Session Times
		Start	End		
☐	Fall/Spring			M T W TH F	
☐	Summer			M T W TH F	

Parent's Mileage Estimate _____

I _____ the parent/guardian of the above named child agree to personally provide for the transportation of my child to and/or from services listed above. In return for reimbursement of expenses in connection with said transportation, I absolve Albany County of any and all responsibility of liability to this transportation.

_____
Parent Signature

_____
Date

Check One

EI	CPSE

County Assigned Mileage

CLAIM FORM

Tax Exempt Tax ID. No. ▶ 14-6002563

Official Use Only Leave Blank

Sold To County Of Albany, New York

Claimant

Address

Parent Transportation

Department Children Youth, and Families
Division For Children With Special Needs

CODE (Transportation)
A2960.4038

Received for Audit
Amount $
Order Extensions

Date Claim Approved

Amount

Signed:
Auditor

Date Paid

Check No.

Request for Payment for Transportation of Children with Special Needs

Child's Name
Last First Middle

School

Month Year

Parent Transportation

Preschool/Therapy Service Days Circle Each

1	2	3	4	5	6	7	8	9	10	
11	12	13	14	15	16	17	18	19	20	
21	22	23	24	25	26	27	28	29	30	31

		Amount
Total Days		
Miles Per Day		
Rate Per Day ▶ (Day miles x .405)		
TOTAL		$

Adjustments Albany County Fiscal Staff Only

Certificate of Claimant

I _____ Do hereby certify that I am
(Print or type name of person certifying, whether claimant, member of firm or officer of corporation)

_____ if individual. Leave blank; if partner, write "a member of the firm (naming firm)"; if corporation, title of officer and name of corporation) and that this claim is true and correct and that the amount claimed is due, owing and unpaid; that the services were actually rendered, the disbursements actually and necessarily made or the supplies or equipment actually delivered and that the consideration has passed to the County of Albany as stated herein; that no Federal or State taxes for which the County is exempt are included in the purchase price. Certified true and correct.

NOTICE TO INDIVIDUAL CLAIMANTS

If this claim is being submitted for payment to an individual for services rendered or for any reason other than reimbursement of expenses incurred on county business, you must supply your Federal Tax ID No. or your Social Security No. in the space provided

Federal Tax Identification OR Social Security Number

CERTIFICATE OF APPROVAL BY DEPARTMENT HEAD OR OFFICER THROUGH WHICH CLAIM ORIGINATED

I hereby certify that the service(s) enumerated in this claim were actually rendered by the persons named; the disbursements made; or the supplies or equipment were actually delivered, accepted, counted and inspected by me and are satisfactory and of the quality specified in such claim; that the contract price has been earned; that the services, disbursements, supplies or equipment were necessary and have been, or will be applied to the use of this department

Claimant

By

Date

Department Head Claim Number Date:

Two Claim Forms Must Be Rendered To Head Of Department For Which Services Or Materials Are Furnished

CLAIM FORM

Tax Exempt Tax ID. No. > 14-6002503

Official Use Only Leave Blank

Sold To: County Of Albany, New York

Claimant

Address

Parent Transportation

Department Children Youth, and Families
Division For Children With Special Needs

CODE (Transportation)
A3000.4010

Received for Audit — Amount $

Order — Encumbrance

Date Claim Approved

Amount

Signed:

Date Paid — Auditor Check No.

Request for Payment for Transportation of Children with Special Needs

Child's Name — Last — First — Middle

School — Month — Year

Parent Transportation

Preschool Therapy Service Days Circle Each

1	2	3	4	5	6	7	8	9	10
11	12	13	14	15	16	17	18	19	20
21	22	23	24	25	26	27	28	29	30	31

	Amount
Total Days	
Miles Per Day	
Rate Per Day > (Payable 1.40)	
TOTAL	$

* Adjustments Albany County Fiscal Staff Only

Certificate of Claimant

I _____ Do hereby certify that I am
(Print or type name of person making claim or claimant, member of firm or officer of corporation)

_____ If individual, Leave blank; If partner, write "a member of the firm (naming firm)";
If corporation, title of officer and name of corporation) and that this claim is true and correct and that the amount claimed is due, owing and unpaid; that the services were actually rendered, the disbursements actually and necessarily made or the supplies or equipment actually delivered and that the consideration has passed to the County of Albany as stated herein; that no Federal or State taxes for which the County is exempt are included in the purchase price. Certified true and correct.

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CERTIFICATE OF APPROVAL BY DEPARTMENT HEAD OR OFFICER THROUGH WHICH CLAIM ORIGINATED

I hereby certify that the service(s) enumerated in this claim were actually rendered by the persons named; the disbursements made; or the supplies or equipment were actually delivered, accepted, counted and inspected by me and are satisfactory and of the quality specified in such claim; that the contract price has been earned; that the services, disbursements, supplies or equipment were necessary and have been, or will be applied to the use of this department

Claimant

By

Date

Department Head — Claim Number — Date

Two Claim Forms Must Be Received By Head Of Department For Which Services Or Materials Are Furnished

Voucher Preparation Instructions/Parent Transportation

1. Your Name
2. Mailing Address
3. Name of Child
4. Name of School
5. Month and Year
6. Round Trip service days: Circle each day you drove your child to school or therapy session
7. Number of days you circled
8. Amount per day = # of miles from your home to school and back home multiplied by .485
9. Claim amount – Total number of days (item 6) multiplied by rate/day (item 9)
10. Your Social Security Number
11. Sign the claim form on the line above where it says claimant
12. One original claim form and one copy must be submitted each month
13. Monthly claim form must be submitted to the County no later than 15 days after the end of each month for which transportation services were provided. The County reserves the right to not accept any claims submitted past the above deadline.

PLEASE SEND ONE VOUCHER FOR EACH MONTH TO:

Albany County Department for Children, Youth & Families
Division for Children With Special Needs
112 State Street - Room 300
Albany, New York 12207

Attn: Fiscal Unit

NOTE: Reimbursement is for transporting CHILD to and from school. Parent can only bill mileage while the child is in the car. If parent transports child only one way, billing can only be for the one way.

If you have any question please call (518) 447-4820