County of Lake California Children's Services
Maintenance and Transportation (M & T) Claim Form

To be reimbursed for M & T expenditures, we must have verification of appointment or hospitalization.

1. Take this form to the medical provider so they can verify appointment was kept;
2. Attach all original or online receipts (if applicable); and
3. Return this form to: ***Lake County CCS, 922 Bevins Ct., Lakeport, CA 95453***

Claimant: _____Phone #:_____
☐ Parent/Legal Guardian ☐ Client ☐ Other _____
Mailing Address: _____
_____
Leave Date: _____ Time: _____ ☐ AM ☐ PM
Return Date: _____ Time: _____ ☐ AM ☐ PM

Requested Reimbursement for:

☐ **Mileage** ☐**Parking Fees** (Original Receipts Included) ☐ **Bridge Tolls** (Original or Online Receipt Included)
☐ **Public Transportation Fares – Taxi, Bus, Uber, Lyft, Rail** (Original or Online Receipts Included)
☐ **Meals** (Original Receipts Included)**:** ☐**One Parent/Legal Guardian** ☐ **Two Parents/Legal Guardians** ☐ **Client**
☐ **Lodging** (Original Receipts Included)

Providers: By completing this form, medical staff is verifying that this CCS client kept their appointment on specified date above at your facility location:

Child's Name: _____ DOB: _____

Date of Appointment: _____Time of Appointment: _____ ☐ AM ☐ PM

Provider Information (Stamp may be used below):

Clinic, Physician, and/or Provider Name: _____

Provider Address: _____

_____

Contact #: _____

Provider: _____ DATE: _____
(Signature Required)

Lake County CCS Staff may contact provider to verify this appointment date and/or time, or to determine if services were covered under a current CCS SAR.

I certify under the penalty of perjury that the within claim and the items as therein set out are true and correct, that no part thereof has heretofore been paid and that the amount therein is justly due me and that the same is presented within 45 days of date of service or hospital discharge inclusive of required receipts.

_____
Claimant's Signature **Date**

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