Dufferin county

MEDICAL TRANSPORTATION AND TRAVEL EXPENSE FORM

Name _____ **Month/Year** _____

Check List: ☑ Check that you have attached the following documents:

☐ Verification of Medical Appointment(s) ☐ Recommendation for Treatment *(if required)* ☐ Receipts for Parking (Parking receipts are required for reimbursement)

MILEAGE: Complete the chart below for mileage based on $0.40 per kilometer.
***NOTE**: Benefits are only paid on a monthly basis. Submit expense form monthly, as benefits are not retroactive.

DATE	PLACE – Full address is required	PURPOSE	KMs
		Total Kilometers	
		Total Kilometers x $0.40/km	

OFFICE USE ONLY
Case Worker #_____ Signature of CW _____ Approved _____

The personal information collected on this form is collected under the authority of the Municipal Act for the purposes of reimbursing expenses. For questions regarding the collection of this information, contact the Ontario Works Program Manager at 519-941-2816 x2203.