Olmsted County Health, Housing and Human Services

Foster Care Provider Request for Payment

Month: _____

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____

Olmsted County Health, Housing and Human Services
2117 Campus Drive SE, Suite 200
Rochester, MN 55904

Receipts for clothing and incidental expenses are required for reimbursement

	Client Name	Service Description	Dates (from-to)	# of Days	Rate	Amount
1						0.00
2						0.00
3						0.00
4						0.00
5						0.00
6						0.00
7						0.00

Total: $ 0.00

I/We declare under penalties of perjury that I/We are making the within claim; that I/We have examined said claim and that the same is just and true; that the money/service therein charged was actually paid/performed for the purpose therein stated; that the services charged are official and are such as are allowed by law; and no part of said claim has been paid.

Vendor Signature: Date: _____