

**REIMBURSEMENT REQUEST**

DMH-CSP-011

Ohio Department of Mental Health  
Community Support Program

The following expenses were incurred for my attendance at:

|                  |       |      |
|------------------|-------|------|
| Name of Event    |       | Date |
| Address of Event |       |      |
| City             | State | Zip  |

|                    |  |    |
|--------------------|--|----|
| Transportation:    | Mileage (personal vehicle) @ _____ miles x \$0.30 per mile | \$ |
| Receipts Required: | Public Transportation (i.e., bus, airline, taxi)           |    |
|                    | Lodging  |    |
|                    | Meals  |    |
|                    | Parking  |    |
|                    | Other (specify)  |    |
| <b>TOTAL:</b>      |  | \$ |

**Travelers Certificate**

I certify that the expenses identified on this form are limited to those which I actually incurred and that these expenses meet the requirements of Rule 126-1-02 of the Administrative Code. In the event that I am driving a privately owned motor vehicle, I also certify that I am insured under a policy of liability insurance meeting the requirements of Section 4509.51 of the Revised Code.

|            |               |       |     |
|------------|---------------|-------|-----|
| Signature  | Soc. Sec. No. | Date  |     |
| Print Name |               |       |     |
| Address    |               |       |     |
| City       | County        | State | Zip |

**For Office Use Only - DO NOT Write Below**

|              |           |      |            |
|--------------|-----------|------|------------|
| Comments     |           |      |            |
| _____        |           |      |            |
| _____        |           |      |            |
| _____        |           |      |            |
| _____        |           |      |            |
| Fund Code    | Check No. | Date | Written By |
| Approved By  |           |      | Date       |
| Vouchered By |           |      | Date       |