MANHATTAN DEVELOPMENTAL DISABILITIES COUNCIL
TRANSPORTATION REIMBURSEMENT FORM

NAME OF PERSON WITH DEVELOPMENTAL DISABILITY: DATE OF BIRTH:

_____ _____

Include only one month's transportation expenses per form. Forms must be received no later than 10 days after the last day of each month.

Month: _____ ***Date of Travel***	***Purpose of Destination:*** *A- Medical Appt B- Therapy C- School Appt D- Other (Explain)*	***Destination Information***			***Means of Travel:*** *A- Public Transportation B- Taxi C- Personal Car D- Other (Explain)*	***Cost of Travel***
		Name and Address of Destination:	***Zip code:***	***Telephone:***		
Ex: 13	*D Swimming Classes*	*Esperanza Center 516 w. 181st Street*	*10033*	*212-928-5810*	*A*	*8.20*
					Total Cost of Travel	

REIMBURSEMENT CHECK SHOULD BE MADE OUT TO:

NAME: _____

ADDRESS: _____

_____

TELEPHONE: _____

Send to:
Transportation Reimbursement
Esperanza Center
516 West 181st Street, 2nd Floor
New York, NY 10033