



Resource Mothers Program  
REQUEST FOR PAYMENT & REIMBURSEMENTS

Name: \_\_\_\_\_

Social Security #: \_\_\_\_\_

Mailing Address where check will be sent:

\_\_\_\_\_  
\_\_\_\_\_

Phone: \_\_\_\_\_

Date of Request: \_\_\_\_\_

Please check one or more:

\_\_\_ **Training Stipend** (\$300)

\_\_\_ **Initial Payment** after first visit (\$250)

\_\_\_ **Final Payment** at completion of pregnancy (\$550)

\_\_\_ **Mileage Expense**

Roundtrip miles to Resource Daughter's home \_\_\_\_\_

Number of trips to Resource Daughter's home \_\_\_\_\_

Roundtrip miles to PKU clinic \_\_\_\_\_

Number of trips to the PKU clinic \_\_\_\_\_

Total Miles \_\_\_\_\_ x \$0.345 cents/mile = \_\_\_\_\_

\_\_\_ **Postage** (Please attach all applicable receipts, keeping a copy for your records).

**Total Amount Requested:** \_\_\_\_\_

Mail this form to:  
Maternal PKU Program  
Children's Hospital, Boston  
300 Longwood Ave  
IC Smith 106  
Boston, MA 02115  
Attn: Melissa Gennaccaro

Or FAX to:  
(617) 734-2652  
Attn: Melissa Gennaccaro

\_\_\_\_\_  
**For office use only**

Date submitted to accounting \_\_\_\_\_