

Janet T. Mills  
Governor

Jeanne M. Lambrew, Ph.D.  
Commissioner



Maine Department of Health and Human Services  
Office for Family Independence  
109 Capitol Street  
11 State House Station  
Augusta, Maine 04333-0011  
Tel.: (207) 624-4168; Toll-Free: (800) 442-6003  
TTY: Dial 711 (Maine Relay); Fax: (207) 287-3455

## MAINE SNAP Employment and Training (SNAP E&T) Contractor Reimbursement Form

CLIENT'S NAME	
CLIENT'S A#	DATE

Organization Staff Portion	
CHECK THE TYPE(S) OF REIMBURSEMENT(S), ENTER THE AMOUNT AND DESCRIPTION, AND ATTACH ALL RECEIPTS.	ENTER AMOUNT
<input type="checkbox"/> Transportation: <b>Bus pass</b> / ticket - <b>How many:</b> <input type="checkbox"/> daily / <input type="checkbox"/> weekly / <input type="checkbox"/> monthly <div style="text-align: right; margin-left: 150px;"><input type="checkbox"/> daily / <input type="checkbox"/> weekly / <input type="checkbox"/> monthly</div>	\$
<input type="checkbox"/> Mileage: _____ miles x Currently Approved Rate (.50 as of 2/1/2024)	\$
<input type="checkbox"/> Dental Care (Limited to \$500 limit per academic year)	\$
<input type="checkbox"/> Childcare (Childcare rates may not exceed the rates set by the Maine Child Care Subsidy Program (CCSP) at: <a href="http://www.maine.gov/dhhs/ocfs/ec/occhs/provider-subsidy.htm">http://www.maine.gov/dhhs/ocfs/ec/occhs/provider-subsidy.htm</a> . Recipients must apply for CCSP funding, and child care will only be reimbursed through E&T when CCSP funding is not available.)	
<input type="checkbox"/> Vision Care (Limited to \$200 limit per academic year)	\$
<input type="checkbox"/> Clothing (e.g. uniforms, interview clothes, shoes, necessary tools, and equipment Limited to \$1000 per calendar year)	\$
<input type="checkbox"/> Tuition: Education (e.g., high school equivalency test, CNA test, short-term contracted training, certificate courses)	\$
<input type="checkbox"/> Books and Educational Supplies (Limited to \$2,000 per academic year)	\$
<input type="checkbox"/> Any other work/training related needs (more detailed justification required below)	\$
<b>DESCRIPTION:</b> Enter justification for each type of reimbursement given (i.e., reason needed)	
APPROVING AUTHORITY'S SIGNATURE, DATE, AND PRINTED NAME	
Client Declaration and Signature	
<p>I understand and agree that:</p> <ul style="list-style-type: none"> <li>I received the above issuance(s) and that this assistance is provided only for the purpose indicated above, and that these funds are not to be used for the purchase of alcohol or tobacco products.</li> <li>I have not received the same type of assistance in the current month from any other organization or program.</li> <li>I understand that selling or misusing the benefit will result in SNAP E&amp;T disqualification and I will have to pay back the funds.</li> </ul>	
CLIENT'S SIGNATURE	DATE