

**SD MILEAGE REIMBURSEMENT FORM – Multiple Vehicles**

This form may be used to reimburse mileage expenses for service-related or personal activities when transportation is provided in a vehicle owned by:

1. a participant/family who use multiple vehicles to transport multiple individuals;
2. a staff person who uses multiple vehicles to take participants for service-related transportation; or
3. any person who uses multiple vehicles to take participants for personal related activities

A separate SD Mileage Reimbursement Form is required for each Participant, Payee, additional dates, or budget line.

Participant \_\_\_\_\_ For Month and Year \_\_\_\_\_

**For Multiple Vehicles Owned by Participant or Staff**

Payee (Vehicle Owner): \_\_\_\_\_

Vehicle owner is:  Participant/Family  Staff (Check one)      Mileage type is:  Service related  Personal (Check one)

Comments:

**Service-related Mileage (Transportation must coincide with an approved Plan activity)**

Date (MM/DD/YY)	Starting Location (Physical Address)	Destination (Physical address)	Support Activity	Miles Traveled	Vehicle Lic. Plate	Driver Initials

**Total service-related miles traveled for the Month:**

**Total Miles** \_\_\_\_\_ **X Federal Mileage Rate** \_\_\_\_\_ = \_\_\_\_\_ **Total Requested Reimbursement**

The vehicle owner name and signature are only necessary if the vehicle owner will be reimbursed for the mileage. The Self-Direction participant or his/her designee must sign in all cases. That signature will verify that mileage information is accurate.

I certify that the travel shown above was necessary in order for me to receive the identified services and/or supports from my SD Plan.

\_\_\_\_\_  
**Signature of Participant/Designee (Required)**

\_\_\_\_\_  
**Date: (MM/DD/YY) (Required)**

Vehicle Owner: I certify that I provided this transportation using my own vehicle.

\_\_\_\_\_  
**Signature of vehicle owner seeking mileage reimbursement**

\_\_\_\_\_  
**Date: (MM/DD/YY) (Required)**

**Signing and submitting false information may lead to a charge of Medicaid fraud**

Remit to: P.O. Box 1320, Monticello, NY 12701

Participant \_\_\_\_\_ For Month and Year \_\_\_\_\_

**For Multiple Vehicles Owned by Participant or Staff**

Payee (Vehicle Owner): \_\_\_\_\_

Date (MM/DD/YY)	Starting Location (Physical Address)	Destination (Physical address)	Support Activity	Miles Traveled	Vehicle Lic. Plate	Driver Initials
<b>Total service-related miles traveled for the Month:</b>						

**Total Miles \_\_\_\_\_ X Federal Mileage Rate \_\_\_\_\_ = \_\_\_\_\_ Total Requested Reimbursement**

**Signing and submitting false information may lead to a charge of Medicaid fraud.**

I certify that the travel shown above was necessary in order for me to receive the identified services and/or supports from my SD Plan.

\_\_\_\_\_  
**Signature of Participant/Designee (Required)**

\_\_\_\_\_  
**Date: (MM/DD/YY) (Required)**

Vehicle Owner: I certify that I provided this transportation using my own vehicle.

\_\_\_\_\_  
**Signature of vehicle owner seeking mileage reimbursement**

\_\_\_\_\_  
**Date: (MM/DD/YY) (Required)**

**Signing and submitting false information may lead to a charge of Medicaid fraud**  
Remit to: P.O. Box 1320, Monticello, NY 12701