INDEPENDENT SUPPORT SERVICES INC.
Make your Own Path

SD MILEAGE REIMBURSEMENT FORM

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 who uses his/her own vehicle;
2. a staff person who uses his/her own vehicle to take a participant for service-related transportation; or
3. any person who uses his/her own vehicle to take a participant for personal related activities.

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

Participant _____ For Month and Year _____

For Vehicle 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**	**Driver Initials**

Total service-related miles traveled for the Month: 0

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

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Participant _____ For Month and Year _____

For Vehicle Owned by Participant Staff

Payee (Vehicle Owner): _____

Date (MM/DD/YY)	Starting Location (Physical address)	Destination (Physical address)	Support Activity	Miles Traveled	Driver Initials

Total service-related miles traveled for the Month: 0

Total Miles _____ X Federal Mileage Rate _____ = _____ Total Requested Reimbursement

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