

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): _____ *(required - "Payee", "Owner type" and "Mileage type" on all requests)*

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

Comments: *****SAMPLE*****
(include name of Driver if not Payee)

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
<i>Same Day</i>					
Important Notes					
Location - Address or Point of Interest should be researchable on Google or MapQuest.					
All lines/columns must be completed to be reimbursed.					
Arrows and Ditto Marks ("") are not acceptable.					

Total miles traveled: _____

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.

****Mary Jones**** *****SAMPLE*****

Signature of Participant/Designee (Required)

Date: (MM/DD/YY) (Required)

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

****Nancy Lee**** *****SAMPLE*****

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

SAMPLE

SAMPLE

Page ____ of ____

Participant _____ For Month and Year _____

For Vehicle Owned by Participant or Staff

Payee (Vehicle Owner): _____

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

Total miles traveled: _____

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.

**** Mary Jones **** ***SAMPLE***

 Signature of Participant/Designee (Required)

Date: (MM/DD/YY) (Required)

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

**** Nancy Lee **** ***SAMPLE***

 Signature of vehicle owner seeking mileage reimbursement

Date: (MM/DD/YY) (Required)