

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 service-related miles traveled for the Month:

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)