Mileage Reimbursement Form

This form may be used to reimburse mileage expenses for **service-related activities when transportation is provided in a vehicle owned by:**
(1) a participant who uses his/her own vehicle or a leased vehicle for service-related transportation;
(2) a staff person who uses his/her own vehicle to take a participant for service-related transportation; or
(3) any other person who uses his/her own vehicle to take a participant for service-related transportation.
(4) Staff are to submit mileage sheets with their timesheets every other week. Travel must be supported in the notes.

The staff name and staff signature are only necessary if the staff person will be reimbursed for the mileage. The Participant or his/her designee must sign in all cases. That signature will verify that mileage information is accurate.

Participant Name: _____ For Month of _____ 2018

For Vehicle Owned by Participant, Staff or Other
If a participant's leased vehicle is used, all mileage (personal and service-related) must be accounted for.
All leased vehicle mileage must be recorded on the reverse side.

Vehicle used was:

Name of Vehicle Owner: _____

Service-Related Mileage (Transportation must coincide with an approved Plan activity/Valued Outcome)

Date (mo/day/yr)	Leaves From:	Goes To:	Purpose of Travel	Miles Traveled	Driver's Initials

Total service-related miles traveled for the month _____

Total Miles _____ X allowed mileage rate of $ 0.5350 (staff allowed mileage rate) (all others allowed Federal mileage rate) = Total Requested Reimbursement

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

I certify that I provided this transportation using my own vehicle:

Signature of staff person seeking mileage reimbursement _____ Date (mo/day/yr) _____ (required)

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 services and/or supports in my Self Directed Budget.

Signature of Participant/Designee (required) _____ Date (mo/day/yr) _____ (required)

Participant: Original to FI