## 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

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)

	Serv	ice-Related Mileage (Tr	ansportation must coincide with an approved Pla	n activity/Val	ued Outcome)	
Date (mo/day/yr)	Leaves From:	Goes To:	Purpose of Travel		Miles Traveled	Driver's Initials
(IIIO/day/yr)					Traveled	IIIILIais
			Total service-related miles traveled for the n	nonth		
		allowed mileage rate of				
Total Miles	X	3	\$ 0.5350 =			
			(staff allowed mileage rate) (all others allowed Federal mileage rate)		Total Requeste	d Reimbursemer
		Signi	ng and submitting false information may lead to a cha	arge of Medicai	d fraud.	
certify that I provi	ded this transportation (	_	,			
Signature of staff person seeking mileage reimbursement					Date (mo/day/yr)	(required)
		Signi	ng and submitting false information may lead to a cha	arge of Medical	d fraud.	
certify that the tra	ivel shown above was ne	=	eive the services and/or supports in my Self Directed Budget	_		
ignature of Partici	pant/Designee (required	)			Date (mo/day/yr)	(required)

Participant: Original to FI