PCCS
reconfiguring humanKind

Mileage Reimbursement

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

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
2. A staff person who uses his/her own vehicle to take a participant for service-related transportation
3. Any person who uses his/her own vehicle to take a participant for service –related transportation.

Participants Name: _____ Month/Year: _____

Person Requesting for Reimbursement Name/Address: _____

Date (mo./day/yr.)	Start Address	Ending Address	Purpose of Travel	Goal #	Miles Traveled
***Signing and submitting false documentation may lead to charge of Medicaid Fraud.**				**Total:** 0	

TOTAL MILES: 0 **x .54.5 = Total reimbursement of $** 0

**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.

Vehicle Owner: By signing below, I certify that I provided this transportation using my own vehicle.

Signature: _____ Date: _____

Participant/Designee: By signing below, I certify that the travel shown above was necessary in order for me to receive the identified services and/or supports from my Self Direction Plan:

Signature: _____ Date: _____

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