

2018 MILEAGE REIMBURSEMENT FORM

Consumer Directed Personal Assistant Program

EMPLOYEE NAME: _____
 CONSUMER NAME: _____

PAY PERIOD ENDING DATE: _____

Date	DRIVING TIME OUT	DRIVING TIME IN	DESTINATION Name & location of Consumer/Store/Doctor Purpose of Travel	MILEAGE BEGIN	MILEAGE END	TOTAL MILES	TOTAL DUE (mileage x.54)
Example: 1/1/2018	10:00:00 A.M.	10:15:00 A.M.	Gerould's Pharmacy - Main Street Elmira, Prescriptions	62005	62015	10	\$4.00
TOTAL MILEAGE Carry Miles and Dollar Amounts							

EMPLOYEE SIGNATURE: _____

DATE _____

CONSUMER (CAREGIVER) SIGNATURE: _____

DATE _____