Mileage Reimbursement Form

This form may be used to reimburse (1) a participant who uses his/her own vehicle or a leased vehicle for service-related transportation; or (2) a staff person who uses his/her own vehicle to take a participant to service-related activities. In this instance, **each staff person** will need to complete a separate CSS-04-MRF.

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

CSS Participant Name: _____ For Month of _____

For Staff or Participant Owned Vehicles Only

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: ☐ Participant's Own ☐ Staff's Vehicle

Staff Name: _____ (only required if Staff vehicle is used)

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

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

Total service-related miles traveled for the month _____

Total Miles _____ X FEA rate of _____ = _____ 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 travel 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 CSS Plan.

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

Participant: Original to FEA