Mains'l FMS Mileage Reimbursement Form

Employee Name: _____ Employee #: _____

Name of Person Receiving Services: _____ Month/Year: _____

Important Information Before Completing This Form

- **Mileage must be approved in the participant's plan:** Please review the plan to ensure you submit mileage only for approved activities. As a reminder, you cannot submit mileage for any medical, dental, or therapy visits covered and paid for by Medical Assistance.
- **The form must be completed in its entirety:** Dates, odometer/trip readings, destination (to/from), total amount being requested are required, and both the worker and the responsible party need to approve this form.
- **Clearly identify each destination.** Full street addresses are not required, but the locations must be specific enough to identify where the trip started and ended.
  Acceptable: Home → Walmart **Not acceptable:** St. Paul → Errands
- **Due Date:** Please complete a minimum of **one form per month** and submit it within two weeks after the end of that month.

Date	Odometer Reading		Destination		Trip
	Start	End	From Name of Place	To Name of Place	Miles
					0
					0
					0
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					0
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				Total Miles:	0
				Mileage Reimbursement Rate:	
				Total Due:	$ 0.00

Employee Signature: _____

Responsible Party Signature: _____

Mains'l Approval Initials: _____ Date: _____ Amount: _____ Notes: _____

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Date	Odometer Reading		Destination		Trip
	Start	End	From Name of Place	To Name of Place	Miles
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					0
				Total Miles:	0
				Mileage Reimbursement Rate:	
				Total Due:	$ 0.00

Employee Signature: _____

Responsible Party Signature: _____

Mains'l Approval Initials: _____ Date: _____ Amount: _____ Notes: _____