Self-Directed SERVICES

IDGS/OTPS MILEAGE FORM

Participant Name (print): _____ Vehicle used was (Circle): Designee/Staff

Date (MM/DD/YYYY)	From Physical Location	To Physical Location	Miles Traveled/Fare Cost
		Total Miles	
		Reimbursement Rate	
		Total 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 and I certify that the travel shown above was necessary in order for me to receive the services and/or supports in my SDS Plan.

_____ _____

Signature of Designee (required) Date (MM/DD/YYYY)