Champions of Homecare

Mileage Reimbursement Request

Staff Name: _____ Staff Phone Number: _____

Client Name: _____

Managing Party Name: _____

- Please complete this form in its entirety for mileage reimbursement.
- CCI can only reimburse for mileage that is in the County approved plan.
- Please note mileage cannot be paid for the following:
  - Medical Assistance reimbursed mileage for doctor's visits, speech, occupational therapy or physical therapy.
  - Mileage related to/from school for minor children.
  - Mileage for vacation.

Date	Destination	Total Mileage
	Total Mileage	

_____	X	_____	=	$ _____
Total Mileage		Per mile County Approved Mileage Rate		Total Mileage Reimbursement

Staff Signature _____ Date: _____

Managing Party Approval/Signature: _____ Date: _____