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 _____ per mile = $_____

Total Mileage — County Approved Mileage Rate — Total Mileage Reimbursement

Staff Signature _____ Date_____

As the participant employer, I acknowledge that it is my responsibility to verify the above-named employee has a valid driver's license and meets state requirements for insurance to cover costs incurred in the event of an accident, while performing tasks within the scope of their employment.

Managing Party Approval/Signature: _____ Date: _____